STATE OF MONTANA

ANALYSIS AND EVALUATION OF CLAIMS PROCESSING AND PAYMENT PROCEDURES

March 1, 1994
Through
February 29, 1996

Prepared Under Contract With:
MONTANA LEGISLATIVE BRANCH, AUDIT DIVISION
PO Box 201705, Helena, MT 59620-1705

STATE OF MONTANA

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March 1, 1994
Through
February 29, 1996

Submitted By:

THE SEGAL COMPANY

5080 N. 40th Street, Suite 400

Phoenix, Arizona 85018

Contact:
MaryAnne L. Watson

(602) 381-4031

MONTANA LEGISLATIVE BRANCH

Legislative Auditor
Scott A. Seacat

Legal Counsel:
John Northey

Deputy Legislative Auditors:
Mary Bryson
Operations and EDP Audit
James Gillett
Financial-Compliance Audit
Jim Pellegrini
Performance Audit

LEGISLATIVE AUDIT DIVISION

October 1996

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the special purpose audit of the Montana Employee Benefit Plan administered by the Department of Administration for the two fiscal years ended February 28, 1996.

The audit was conducted by the Segal Company under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

The agency's written response to the report recommendations is included in the back of the audit report.

Respectfully submitted,

Scott A. Seacat
Legislative Auditor

96C-09

Room 135, State Capitol Building, PO Box 201705 Helena, MT 59620-1705
Phone (406) 444-3122 FAX (406) 444-9784

THE SEGAL COMPANY

5080 North 40th Street
Suite 400
Phoenix, Arizona
85018
602-381-4000
FAX: 602-381-4090

October 31, 1996

State of Montana
Office of the Legislative Auditor
Helena, Montana

Re: **State of Montana Employee Benefit Plan**

Ladies and Gentlemen:

It is a pleasure to submit this report, which sets forth the results of our evaluation of the claims processing and payment procedures utilized by Blue Cross and Blue Shield of Montana (BCBS) and case management services provided by Vocational Resources Incorporated (VRI) for the State of Montana Employee Benefit Plan.

Our onsite BCBS review was conducted in August, 1996 and the analysis of VRI case files was performed during September, 1996. The preliminary report was presented to BCBS, VRI and the State's Department of Administration for their review. Their responses are provided in Sections VIII, XIII and XIV, respectively. As appropriate, issues of clarification addressed in these responses have been incorporated in this final report.

This report would be incomplete without recognition of the cooperation and assistance of BCBS and VRI staff and State personnel extended to us during the onsite audits and review process.

On behalf of The Segal Company, we appreciate the opportunity to assist the State of Montana in this project. We look forward to discussing this report with you and answering any questions you may have.

Sincerely,

MaryAnne L. Watson

MaryAnne L. Watson, HIA
Manager, Claims Auditing Services

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Enclosure

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SECTION I - INTRODUCTION

The State of Montana provides self-insured medical benefits for active employees and retired employees electing to continue coverage under the State Employee Benefit Plan, as well as for their dependents. Self-insured dental benefits are provided for active employees and retirees to age 65. The State has contracted with Blue Cross Blue Shield of Montana (BCBS) to provide claims administration services only and utilizes the medical management services of VRI, a Montana-based managed care organization. VRI performs precertification of elective hospital admissions, concurrent and retrospective review as well as individual case management, also referred to as ICM services.

Purpose of the Audit

Montana State Law (Section 2-18-816) requires that the State employee group benefit plan be audited every two years. The audit must cover the two-year period since the last audit and be conducted by or at the direction of the Legislative Auditor.

The prior report prepared by The Segal Company reviewed the two-year period March 1, 1992 through February 28, 1994. Due to implementation of a new claims processing system for the State's plan on October 1, 1992, the two-year period was reviewed as three separate time periods.

Our current review encompasses a single two-year period of March 1, 1994 through February 29, 1996. As requested by the legislative auditor, this claims audit includes a review of case management services provided by VRI.

Dates and Locations

Preliminary steps in coordinating this review with BCBS included a June 3, 1996 request for claims tape data, review of administrative procedures and previous audit recommendations, and the request of information to be supplied by Vocational Resources Incorporated (VRI). Ms. Peg Hasner, Internal Auditor, was our primary BCBS contact assisting in coordinating all phases of this project.

The onsite visit commenced on August 12, 1996 with a review of changes in administrative procedures since the prior audit period. Ms. Hasner assisted with this phase of the audit in addition to the daily review of claim audit worksheets. Mr. Karl Kreiger, Internal Auditor, also assisted in the daily review of claim audit worksheets.

Our administrative BCBS review included an interview with Ms. Carlotta Hecker of Vocational Resources Incorporated (VRI) regarding large case management procedures. Eligibility updates for four COBRA participants were also reviewed based on verification of eligibility information obtained from Mr. Larry Tobiason, State of Montana Employee Benefits.

The BCBS exit interview was held on August 16, 1996 with Ms. Peg Hasner. Clarification of outstanding claims issues addressed during the onsite review were provided via facsimile on August 21, 1996.

VRI's audit was performed during the period September 16, 1996 through September 26, 1996, through review of copies of VRI's case management, savings and billings records. This offsite audit format was utilized, reviewing hard copy records at the Phoenix office of The Segal Company.

Segal Audit Personnel

Ms. Carol Hoel and Ms. Kimberly Keenan visited BCBS's Helena office to discuss changes in administrative procedures, actions taken or current status of prior report recommendations, and perform the review of sampled claims payments. The large case management interview was conducted by Ms. Hoel; verification of eligibility procedures was accomplished by Ms. Keenan. Prior to joining the Segal Audit Division, Ms. Hoel and Ms. Keenan were employed in claims administration for 17 and 13 years, respectively.

The review of case management services provided by VRI was conducted by Nancy R. Hakes, RN, MSN, a healthcare consultant with The Segal Company also in Phoenix, AZ. Ms. Hakes is a registered nurse with over 10 years of clinical hospital nursing experience and a Master's Degree in Nursing. She has served as Director of Utilization Management and Quality Assurance for a Health Maintenance Organization, as Manager of quality auditing for Medicare Risk HMO's, and as Director of Operations for a nationwide utilization management organization for group medical, Medicaid and Workers' Compensation case reviews.

Segal's audit division is under the direction of Mr. John J. Coyle, Senior Vice President and Benefits Consultant. Ms. MaryAnne Watson, Claims Auditing Services Manager, coordinated the reviews with the State, BCBS and VRI. Ms. Watson also conducted the independent review of the auditor's report.

The stratified selection was performed by actuarial staff at the direction of Stephen A. Meskin Ph.D, Senior Health Actuary. Statistical analysis was performed by Dr. Meskin.

SECTION II - HIGHLIGHTS

This report analyzes and evaluates claims administration and case management services provided to the State of Montana during the period March 1, 1994 through February 29, 1996. The review of Blue Cross and Blue Shield of Montana (BCBS) is outlined in Sections III through VIII; Vocational Resources Incorporated (VRI) is discussed in Sections IX through XIII. Section XIV contains the State of Montana Department of Administration's response to our report.

Blue Cross and Blue Shield of Montana

- This review analyzes and evaluates claims processing and payment procedures utilized by BCBS in their administration of the self-funded medical benefits provided by the State of Montana.

- Day-to-day claims processing procedures utilized by BCBS were reviewed for updates since the prior audit period. Section III outlines changes in these procedures and provides recommendations as appropriate.

- Changes in State administration procedures for eligibility determination are addressed in Section IV.

- Our evaluation included a review of 200 claims transactions finalized during the period March 1, 1994 through February 29, 1996. Benefits paid for 381,000 claims during this two year period totaled $64,514,917.43.

- Claims reviewed were chosen by stratified dollar amount to allow for a more quantifiable degree of confidence in the actual error rate by an adjustment to the observed accuracy levels. In this adjustment, the accuracy rates in each strata are weighed according to the size of the strata.

- Accuracy levels achieved on the claims audited during this period (March 1, 1994 through February 29, 1996) are shown below. Based on the sample selected, BCBS has achieved each industry standard.

Performance Category	Accuracy Levels	Industry Standards
Financial Dollar Value	99.69%	99%
Processing (Number of Claims Without Error)	95.95%	95%-90%
Payment (Number of Claims Without Financial Error)	97.56%	97%-95%

- During our review of benefit payments, a possible underpayment was detected on a claim selected for audit. No error was assigned and this claim has not been included in the above error rates but is discussed in Section V so that benefit determination can be considered.

- Detailed descriptions of the errors found during this review, and included in the reported accuracy levels, are presented as Exhibit A of Section V. Claims BCBS feels were properly adjudicated have been so noted.

- Turnaround time captured on our sample of 200 claims reflected an average of 8.8 business days. A detailed analysis of the extrapolated results, indicating that 90% of all claims were processed within 11 days, is presented as Exhibit B in Section V.

- Prior audit recommendations are revisited in Section VI. As appropriate, we have identified the current status or actions taken towards resolution.

- Section VII summarizes our audit results and provides recommendations that are intended to improve overall claims efficiency and accuracy of claims administration.

- Blue Cross Blue Shield of Montana was provided a draft report for review and comment. Their response is presented as Section VIII.

Vocational Resources Incorporated (VRI)

- Section IX provides a general introduction to case management services that may assist in understanding audit findings and recommendations contained in this report.

- Large case management services performed by VRI have been outlined in Section X.

- The 25 cases randomly selected for audit varied by patient age, diagnosis and type of services received. Findings and commentary for each file are detailed in Section XI.

- VRI reported total ICM savings of nearly $467,500 on the cases selected for this review; however, file documentation makes it impossible to substantiate this amount. Recommendations to improve handling and documentation of cases were provided to VRI in our draft report. These issues are summarized in Section XII.

- The purpose of case management for the State of Montana needs to be clarified. Suggestions to the State are presented in Section XII.

- VRI's response to their portion of our draft report is presented in Section XIII.

Following review of BCBS and VRI's respective responses to the draft report, appropriate notations were made and the final draft report was mailed to the State of Montana Department of Administration. Their response is presented as Section XIV.

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Our report would be incomplete without recognition of the cooperation and assistance of BCBS and VRI staff. BCBS staff demonstrated a strong commitment to the constructive approach intended by this audit, particularly Ms. Peg Hasner and Mr. Karl Kreiger, who provided assistance during the onsite audit and review process. Additionally, we thank Ms. Carlotta Hecker for her assistance in coordinating the VRI in-house review.

SECTION III - BCBS ADMINISTRATION PROCEDURES REVIEW

Self-funded medical benefits provided by the State of Montana are administered by Blue Cross and Blue Shield (BCBS) in their Helena, Montana claims office.

As part of our audit we reviewed changes in general procedures since our prior report that were specific to BCBS's day-to-day administration of claims processed for the State Plan. This review included personal interviews, written policy procedures and documentation, and a tour of the Helena Service Team area dedicated to the State Plan.

Administrative Procedures Reviewed

Our administrative review focused on the following general areas:

- Administrative Staff
  - division of responsibilities established for effective administration of the Plan
  - experience of staff assigned to the Plan
  - training of new examiners and continued educational programs
  - quality assurance programs to monitor compliance with established procedures
- Mail Handling System
  - receipt, opening, sorting, front end entry, and distribution of mail
  - storage and retrieval of claims documentation
- Enrollment and Eligibility Updates to the Claims Adjudication System
- Communications to Participants and Providers
  - customer service accessibility
  - experience of customer service personnel
  - forms used in the submission of claim charges
  - requests for additional information and follow-up procedures
  - denial and appeal procedures
- Processing Guidelines
  - procedures and guidelines used in the adjudication of claims
  - reference materials available to examiners
  - interface of the claims adjudication system with precertification, utilization review, and large case management determinations
  - hospital audit guidelines and procedures

- Detection and Investigation of:
  - pre-existing conditions
  - on-the-job injuries/illnesses (Workers' Compensation)
  - third party liability (subrogation)
  - coordination of benefits
  - full-time student and handicapped child provisions
  - fraudulent claims
  - unbundled claims and inflated codes

- Maintenance of Fee Schedules and Provider Files
  - additions and deletions to provider records
  - determination of, and updates to, usual, customary and reasonable (UCR) fee schedules for member, nonmember and preferred provider networks

- Claims Processing System
  - personnel authorized to access the claims system and the extent of their authority
  - duplicate payment edits
  - system updates for changes in plan design

- Financial Procedures
  - draft issuance, maintenance of check registers and reconciliation with monthly bank statements
  - security of blank draft stock, including procedures for storage, signature and authorized access
  - handling of voided, duplicate, stale dated and stop-payment drafts
  - recovery of overpaid claims and credit back to the Plan's experience

Within each general category listed above, our audit verified that BCBS's procedures are within the range of generally accepted practices followed by the claims paying and insurance industry. As appropriate, recommendations intended to improve overall claims processing efficiency have been provided for consideration by the State and BCBS. The following comments apply to areas we believe to be of special relevance to the State of Montana.

Administrative Staff

Established specialized departments continue to assist in the effective flow of administrative duties (*e.g.* mail, front-end batch and entry, internal audit, and provider maintenance).

Effective December 1, 1995, Service Teams have been developed to increase productivity and enhance customer service to all BCBS beneficiary members. Each service team performs the core activities related to a beneficiaries needs (*e.g.* error resolution, member accounting, utilization review, and customer service). Each team has a team coach; team leaders oversee more than one team to assure consistency and compliance with BCBS procedures. Three accounts have been assigned to the State's Helena service team which is comprised of 16 full-time employees (10

customer service representatives, an adjustment processor, 3 error resolution technicians and 2 member account representatives).

Training techniques include such avenues as classroom education, one-on-one evaluation, "as needed" for major enhancements or procedural changes, and memo updates. Members of different service teams meet regularly as a specialized department (*i.e.* customer service) for training and procedure updates.

Internal audits are performed by an independent BCBS unit on a post-pay basis. The percentage of claims to be randomly sampled is based on the production and performance of claims processed from the prior quarter. Internal parameters and quality assurance goals are set by NMIS and monitored by the internal audit department. BCBS accuracy goals remain at 99% financial and 97% overall processing.

The Montana BCBS Internal Audit Department is in the process of preparing for the initial audit following establishment of the Service Teams. This audit will assess the effectiveness of this service approach.

Mail Handling

Mail is received in both the Helena and Great Falls BCBS mail rooms. All mail is opened and handled on a daily basis. Special addressee mail is delivered direct to the appropriate party. Helena receives an estimated 20,000 pieces of mail daily, Great Falls receives an estimated 55,000. Of these totals, approximately 85% of all mail received are actual claims.

Mail received in Helena is sorted for special attention and prescription drug claims. Claims documents received in Helena are batched and sent by daily courier to Great Falls for handling.

The Great Falls mail room performs an additional sort by claim type (*e.g.* hospital, dental, medical). Claims are then delivered to the Entry Department which examines claims for completeness, batches each claim type into groups of 100 or less, and prepares the claims for microfilming. Next, batches are manually logged for claims volume by claims type and delivered to Micrographics for filming. Upon completion of filming, Micrographics returns the claims to the Entry Department where the same person who batched the claims enters them into the front-end claims system.

Electronic submissions represent 82% of hospital claims; a substantial increase from 39.1% reported during the 1992-1994 audit period. Submissions for physicians (53%) and Blue Shield 65 plans (78%) remained comparable; previously reported at 51.8% and 77.1% respectively.

Enrollment and Eligibility Updates

The State makes appropriate employee payroll deductions for coverage under this Plan and is responsible for collection of all self-payment and COBRA premiums. Notification of all eligible plan participants and respective coverage changes are made via tape.

BCBS continues to update their system within three days of receipt of the State's eligibility tape. The State's implementation of a new payroll system on September 1, 1994 has had no effect on internal BCBS procedures.

Changes in State procedures are included in Section IV of this report.

Communications To Providers and Participants

Standard form letters requesting additional information to properly process a claim are either generated by a system edit (*i.e.*, accident details or coordination of benefits) or are sent by an examiner. One request is sent prior to denial of the claim for lack of information; the claim is reopened when the required information is received. The number of follow-up days prior to denial is determined by the type of information being requested.

Explanation of Benefits (EOB) are generated by the system and continue to be distributed as applicable to the specific claim (*i.e.* the subscriber for each claim processed, assigned allied providers, and assigned out-of-state providers with payment exceeding $300.00).

Draft distribution is performed weekly based on the provider type: Monday provider batch drafts are printed for participating providers; allied provider payments are issued on Tuesday; Friday all participating physician drafts are released. Employee drafts and EOBs are distributed on Monday, Tuesday, Thursday and Friday. Participating providers continue to receive a payment register with their bulk payments.

Customer Services responsibilities have been assigned to the service team dedicated to the State of Montana. The ten customer service representatives on this team receive between 650 and 750 telephone inquiries each week. These representatives are responsible for responding to verbal and written participant and provider requests. The scope of the representatives' responsibilities has been expanded to also include the handling of certain types of claims adjustments allowing for prompt resolution of claim inquiries without time delay caused by referral to a processor. BCBS indicates that 91% of all telephone inquiries are handled without a referral or return call being necessary. A new customer service software program has been recently implemented to facilitate greater accuracy and consistency of handling phone inquiries.

Claims Processing Procedures

Claims for the State of Montana continue to be initially examined and data entered (front-end entry) by Great Falls personnel. Claims that do not pass the automated system edits are suspended and sent by courier to Helena. The system automatically requests additional information (*i.e.* other insurance information) based on system edits of claims data entered.

Front-end claim entries appear on BCBS's Long Range System Planning (LRSP) claims adjudication system for review and final determination by Helena's Error Resolution Technicians. Three edit technician positions have been established for the State of Montana service team. Each technician handles all types of suspended claims, allowing one BCBS technician to follow the claim through to payment. Certain edits requiring medical review or pre-existing investigation are referred to the utilization review nurse dedicated to the service team. Error Resolution Manuals provide technicians with detailed explanations and instructions for the proper handling of each claims edit.

This procedure differs from previous claims handling by separate divisions with specialized responsibilities. The purpose of this change is to reduce the amount of internal delay time and to provide improved service to participants.

Internal Utilization Review (UR) services are divided by hospital bill audits and medical review. During review of these claims, nurses also look for other internal edits such as review of supplies. UR nurses are now dedicated to service teams and cross trained to handle multiple suspension edits at one time.

Precertification and Large Case Management

Precertification and Large Case Management services have been contracted with Vocational Resources Incorporated (VRI) effective November 1, 1994. Precertification services also include retrospective review of hospital confinements where notification was not received prior to admission.

Claims and services to be considered for large case management are referred through several methods: precertifications are edited by diagnosis and forwarded as appropriate; employers and providers contact VRI directly regarding potential large cases; and participants and family members may request services which initiate large case management. VRI offers a wide range of services which may or may not be in lieu of current hospitalization. VRI reports their approach is proactive with the goal of preventing future hospitalization and other large dollar claims caused by neglect of an on-going condition or illness.

Negotiated extra-contractual services are submitted to the State for payment. Monthly reports of services are provided to the State for review.

Subrogation/Third Party Liability

BCBS has revised procedures for documenting third party liability claims since the last review period. Previously, BCBS maintained a log that combined data on active subrogation claims for all plans. This procedure has been changed to identify claims separately by plan, making individual reports available to the State. The format of this report was determined in conjunction with the State during a meeting held for that purpose on October 12, 1995.

Procedures for presenting automated reports to the State on a regular basis were also discussed but it appears the issue was unresolved. BCBS indicated automated reporting would require installation of personal computers in the Other Party Liability (OPL) department, implementation of the data scan product, and training. Steps have not been taken to implement this procedure and our concern is that reporting is not being regularly provided in an alternate format.

When the OPL team has an active subrogation case in which the attorney or participant is requesting BCBS assistance in settlement or negotiation, the case is forwarded in its entirety (including claim summary) to Vivian Hammill at the State of Montana Department of Administration. At that point, Ms. Hammill takes control of future recoveries.

Payments voluntarily returned to the OPL team by the participant or other party are accepted and adjusted on behalf of the State. However, BCBS states they are not notified of recovered funds sent to Ms. Hammill and therefore cannot perform file adjustments. Consequently, logs maintained by BCBS detail only the funds returned to the OPL team and do not reflect funds returned to the Department of Administration.

Reimbursement Allowances

A major change in administering out-of-state claims went into effect beginning March, 1994. At that time BCBS of Montana began participating in the nation-wide processing system, Interplan Teleprocessing System (ITS). This system allows BCBS of Montana to benefit from other state BCBS preferred provider and discounted hospital arrangements. The BCBS office in the state where the participant received services verifies provider eligibility, prices the claim and then provides that information to BCBS of Montana for adjudication of benefits.

Claims Processing System

Under the LRSP system, member payment history is maintained online for 24 months and is then archived. While this in an online archive, only a summary format is retained for viewing. Microfilm documentation of archived history details is maintained indefinitely. BCBS indicated that a claim detail history could be obtained overnight or retrieved the same day if necessary. However, in the course of the current claims review process, information requested for same day delivery was not available until the following work day.

Reports

BCBS continues to provide reports for tracking Plan activity as required by their service agreement with the State. After system conversion to LRSP in 1992, there was concern over the reporting format for detailed claims information. In April, 1996, BCBS provided the State with standardized annual reports for 1994 and 1995; our BCBS contacts are not aware of any difficulty in the State's ability to obtain necessary information from those reports. We recommend that BCBS contact the State to determine if their report requirements are being met or if assistance is required in interpreting the reported BCBS information.

Financial Procedures

Refund of overpayments made to participating providers continue to be deducted directly from the provider's next batch draft; a corrected EOB explaining the overpayment refund is sent to the participant. Overpayments are pursued from the participant or allied provider when the amount exceeds $25.00. All underpayments are corrected as they are identified. The only exception to these procedures pertains to claims where the State was involved with the determination of claim benefits. In those cases, the State is contacted for directions on making additional benefit payments or reclaiming overpayments.

Claim Control Measures

Our review confirms the following claim control measures utilized by BCBS for processing and payment of claims. These are consistent with those measures we have seen followed by other insurance carriers and third party administrators.

- Effective December 1, 1995, a dedicated Service Team comprised of members from various core departments (*i.e.* customer service, error resolution, adjustments, utilization review) has been assigned to the State.

- Eligibility updates are entered into the claims system within three days of receipt.

- System access is limited through the use of passwords to specific functions required by an employee's job.

- Original claim documentation is reviewed to determine if the information provided is adequate to process the claim. As necessary, additional information is requested. Photocopies and incomplete documentation is verified with the provider of service.

- System edits alert technicians to the potential for pre-existing conditions, coordination of benefits and claims involving third party liability.

- Error resolution manuals provide step-by-step instruction for adjudication of claims that do not clear automated system edits.

- Benefit limitations are applied as outlined in the Summary Plan Description.
- Automated reduction of submitted charges to appropriate UCR schedules.
- Inpatient hospital bills are reviewed by the BCBS Utilization Review department to determine if audit is warranted.
- Precertification authorizations are loaded directly into the LRSP claims process system via a nightly data transfer process from VRI.
- VRI staff negotiates with providers who are requesting inpatient confinement for a procedure that can be performed on an outpatient basis to assure treatment is appropriate and cost effective.
- Potential large case management claims are automatically forwarded to VRI for review and handling. Claims are identified by diagnosis code, hospital stays of seven days or longer, and multiple (3 or more) hospital admissions during a 12 month period.
- Provider edits identify services for review that may not be appropriate for the billing physician's specialty.

SECTION IV - STATE ADMINISTRATION PROCEDURES REVIEW

The State of Montana Department of Administration implemented two changes in their procedures subsequent to our prior report.

Enrollment and Eligibility

Our previous review identified discrepancies in termination dates between the State and BCBS records for three self-pay participants. The State implemented a new payroll system effective September 1, 1994 which internally reconciles premium payment, coverage periods and coverage type and was expected to eliminate State and BCBS discrepancies. We reviewed eligibility dates for four COBRA participants; in each case the termination dates as reported by the State were consistent with the eligibility records of BCBS.

Procedures for reviewing discrepancies in specific member eligibility reported by BCBS have not changed and continues to be an area of concern. Delay time prior to the State's review of the report can result in payment of claims for participants past the termination date of coverage. Retrospective adjustments of paid claims may prove difficult and unsuccessful if benefits cannot be recovered from a terminated participant or non-participating provider.

We recommend the State review their procedures for providing timely review of BCBS eligibility discrepancy reports and coordinate efforts with BCBS to assure benefits are not paid in error.

Subrogation/Third Party Liability

The State and BCBS met on October 12, 1995 to discuss steps in coordinating the handling of active subrogation cases. BCBS indicated that manual reports could be produced since automated reporting would be cost prohibitive.

Our prior report suggested that a log of active cases be maintained to enable the State to adequately track the impact of Statute 2-18-902 on the overall recovery of the Plan. Our current review does not indicate that this recommendation was initiated on a 6-month trial basis as discussed in the State's response to our 1994 report.

BCBS and the State should define subrogation reporting procedures to ensure that the full claims picture is captured. Not only is it important for BCBS to provide these reports to the State on a regular basis, but it is equally important that the State notify BCBS of benefit recoveries to ensure proper file documentation and adjustment to participant claims history.

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SECTION V - BCBS CLAIMS AUDIT REVIEW

A total of 200 claims were selected by stratified dollar amount from all claims processed during the period of March 1, 1994 through February 29, 1996. The selection was based on a 95% confidence level, +/-3% interval and an expected error rate of 3% or less. The 200 claims audited amounted to $3,071,034.09 in amount paid by BCBS on behalf of eligible participants and their dependents.

For purposes of this audit, a claim was defined as "all charges submitted and processed under one claim number." In preparing claims data for selection, it was necessary to determine the net paid amount following adjustments.

Prior history and accumulators (deductibles, coinsurance and benefit maximums) were reviewed, as applicable, on each claim. In addition to verifying the amount paid, the claims audited were thoroughly reviewed to determine that:

- Claims were paid in strict accordance with the provisions of the Plan.
- Amounts paid were within the designated member and non-member reasonable and customary allowances and/or preferred provider network fees for the area where treatment was rendered, taking into consideration the severity of the condition for which treatment was rendered. The scope of this audit did not include a review for medical necessity, but did consider if reviews were obtained when appropriate.
- Claims were paid only on behalf of eligible individuals as shown on the system's eligibility records.
- Claim forms, as applicable, were adequately completed with all data necessary to properly process the claim.
- Appropriate documentation (provider bills, physician statements, surgical reports, utilization review determinations, etc.) was on file for claims paid and verified when necessary.
- Benefits were paid under the proper benefits classification, diagnostic and procedure codes.
- Benefit maximums, deductibles, coinsurance levels and out-of-pocket maximums were properly applied, where applicable.
- Arithmetic calculations were correct.
- Coordination of benefits, subrogation and pre-existing provisions were enforced, where applicable.
- Duplicate payments were properly denied.

- Claims were paid to the proper party, (i.e., the provider of service if benefits were assigned - claimant if benefits were not assigned).

- Turnaround time for processing and payment of complete claims was within acceptable industry standards.

Selection of Claims

The sample of claims selected for examination was stratified by dollar amount to give large claims more valid representation in the sample. Because the greater percentage of claims processed in most plans represents a nominal dollar value of individual and collective benefit payments, a pure random selection cannot assure that claims will be selected from all types of benefits or provide valid representation of higher claims payments that may require additional review and/or expertise.

The methodology of our stratified selection process utilizes formulae designed to take full advantage of statistical sampling procedures that allow us to have a quantifiable degree of confidence that the results obtained in our audit sample are a true reflection of the actual way all claims were processed during the audit period.

Determination of Errors

Processing errors are classified as "payment" or "procedural"; procedural errors do not involve a variance in payment. Claims containing multiple errors are only counted as one error in determining the accuracy levels achieved in this report. If a payment error also contained a procedural error, it was counted as a payment error.

All errors were reviewed and discussed daily with BCBS's Internal Audit Division. Copies of all audit worksheets containing errors and/or comment were provided to Ms. Hasner prior to our departure from the onsite visit.

Processing Accuracy

Of the 200 claims audited, 189 were processed without error. The number of procedural errors was 1 and the number of payment errors was 10 for a combined total of 11.

The total dollar amount paid during the audit period was $64,514,917.43; total dollar amount paid under all claims audited was $3,071,034.09. The dollar amount of payment errors in our sample amounted to $5,872.77 ($5,750.56 in overpayments and $122.21 in underpayments).

A statistical adjustment has been made to our initial audit findings in order to estimate a true accuracy rate for all claims processed during this audit period. The following chart outlines the statistical analysis of accuracy levels and provides a comparison to industry standards.

Performance Category	Accuracy Levels	Industry Standards
Financial Dollar Value	99.69%	99%
Processing (Number of Claims Without Error)	95.95%	95%-90%
Payment (Number of Claims Without Financial Error)	97.56%	97%-95%

Summary of Errors

Payment and procedural errors identified in the review of 200 claims are categorized by type of error as follows:

Type of Error	Payment	Procedural
Noncovered services paid in error	5	-
Inpatient medical equipment expenses	2	-
Coordination of benefits	1	-
Emergency room benefit	1	-
Retroactive change in eligibility status	1	-
Data entry	-	1
Total	10	1

A detailed listing, Exhibit A, of payment and procedural errors identified by audit worksheet number are included at the end of this section. A possible underpayment identified on one claim is noted for the State's review but has not been included in the reported error rates.

It is recommended that all claims on which underpayments were made be reopened and additional payments sent to the employee with an explanation of the reasons for the additional payment. As a rule, claims which have been overpaid are also reopened and the overpayment is either repaid by the employee or recouped on future claims with proper notification to the employee. Due to the time and expense related to claims re-processing, BCBS has established a $25.00 threshold for recovering and adjusting overpayments.

Turnaround Time

Turnaround time is calculated from the date all information required to process a claim is received to the date the claim is processed by payment or denial. Claims which require additional information are calculated using the longest interval between the received date and date the claim is pended, or the date a response is received and the claim is processed by payment or denial. This analysis includes routine delays due to internal review for medical necessity, audit, etc., and excludes delays realized for draft issuance.

As noted in our analysis of accuracy levels, the process of stratification requires an adjustment in our audit observations. This is also true for the analysis of turnaround time. Accordingly, our analysis weights claims by strata, giving due consideration to the processing complexity for claims that are similarly grouped (*e.g.* small dollar claims require less time to process than large dollar claims subject to internal reviews).

Per the State's prior request, three calculations for turnaround time have been provided:

- Mean - 8.81 business days
  The date midway between the earliest and latest values in the date range;

- Mode - 2 business days
  The number of days within the date range which indicates the greatest number of claims processed; and

- Median - 2 business days
  The specific date within the date range at which 50% of the claims were processed prior and 50% processed after that specified date.

Based on the extrapolated analysis for the 200 sampled claims, 87.46% of all claims were processed within 10 business days. This is slightly below industry guidelines which suggest that 90%-95% of all claims be processed within 10 business days of receipt.

A detailed analysis of the turnaround time observed on the claims audited is included as Exhibit B at the end of this section.

Worksheet #	Over/(Under) Payment	Explanation
18	($22.65)	Retroactive change in eligibility status (from HMO to traditional) was not identified through BCBS standard procedure for correction of prior benefit payments.
25	NA	Incorrect month and date of service was entered.
52	($1.84)	Incorrect calculation of BCBS benefit secondary to Medicare.
77	($68.24)	Emergency room charge was denied; however, treatment and diagnosis meet BCBS definition of medical emergency. BCBS disagrees, stating claim adjudication is based solely on diagnosis; claims are not reviewed for services rendered.
106	($17.32)	Use of durable medical equipment during inpatient confinement should be reimbursed as a hospital ancillary expense. BCBS's corporate policy is to reimburse all HMO durable medical equipment at the lower benefit level (80%).
156	($1.76)	$4.86 underpayment due to hospital's erroneous classification of ancillary expense (use of a surgical cautery machine) as durable medical equipment resulting in lower benefit level; $3.10 overpayment of personal hygiene charges (comb, toothbrush, and toothpaste). BCBS disagrees with the underpayment, stating they may give recommendation but do not change hospital codes.
175	$154.20	$114.60 overpayment due to incorrect entry of noncovered expense (priority lab fees); $39.60 overpayment of personal convenience charges (pacifiers).
176	$5,478.90	Payment of noncovered expenses: $4,197.60 nutrition care services; $1,252.50 priority lab fees; $28.80 personal convenience charges (pacifiers).
177	$105.56	Blood bank transportation fees were paid in error.

Worksheet #	Over/(Under) Payment	Explanation
178	Other Claim Matter (not included in error rates)	An automatic system edit, based solely on the hospital's primary diagnosis, resulted in denial of a $1,080.00 inpatient charge for an air fluidized support bed without review for medical necessity. We recommend a threshold amount be established by which such charges would be suspended for medical review prior to denial. BCBS has clarified that all air fluidized beds suspend for review. This claim was reviewed to determine the medical necessity of the air fluidized bed.
192	$11.90	Telephone consultation charge was paid in error.
193	($10.40)	Incorrect calculation of noncovered charges due to hospital credits.
Total	$5,872.77	$ 122.21 Underpayments (6) $5,750.56 Overpayments (4) Procedural Errors (1) Other Claim Matters (1)

EXHIBIT B - TURNAROUND TIME ANALYSIS

Number of Days	Number of Claims	Individual Percent	Cumulative Percent
0	6	9.94%	9.94%
1	27	17.18%	27.12%
2	30	21.28%	48.40%
3	18	13.16%	61.56%
4	12	8.39%	69.95%
5	12	6.09%	76.04%
6	10	1.94%	77.98%
7	8	3.37%	81.35%
8	4	.28%	81.63%
9	9	3.46%	85.09%
10	6	**2.37%**	**87.46%**
11	3	2.17%	89.63%
12	5	1.64%	91.27%
13	6	2.03%	93.30%
14	4	2.22%	95.52%
15	3	0.00%	95.52%
16	4	1.84%	97.36%
17	2	.02%	97.37%
18	4	.08%	97.46%
19	4	.36%	97.81%
20	2	.06%	97.87%
21	2	.00%	97.87%
22	2	.07%	97.95%
23	1	.00%	97.95%
24	1	1.66%	99.60%
25	2	.02%	99.62%
26	3	.01%	99.63%
27	1	.17%	99.80%
28	1	.00%	99.80%
29	1	.17%	99.97%
34	1	.00%	99.97%
38	1	.00%	99.97%
41	1	.00%	99.97%
42	1	.00%	99.97%
44	1	.00%	99.98%
51	1	.00%	99.98%
70	1	.00%	100.00%
Total	200	100.00%	100.00%

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SECTION VI - BCBS PRIOR AUDIT RECOMMENDATIONS

Our report on the previous audit period of March 1, 1992 through February 29, 1994 was issued in September, 1994. That report contained twelve recommendations. Following is an abstract of each recommendation including the State Department of Administration response and resolution or current status as available.

1. **Subrogation/Third Party Liability**

   Segal: BCBS should advise the State of all potential subrogation cases giving the State the option to pursue those claims as provided within legislative Sections 2-18-901 and 2-18-902. BCBS should also maintain a log of active cases separately from other plans and report this information to the State monthly. This will enable the State to adequately track the impact of statute 2-18-902 on the overall recovery of the Plan.

   State: While recognizing the difficulty of subrogation rights based on statutory restriction, the State agrees to implementing this recommendation for a trial period of six months to assess the merits of expanding recovery efforts. The State will provide BCBS with information on case disposition and any recoveries.

   Resolution: BCBS manually maintains a separate log of active subrogation cases for the State in a format determined jointly during a October 12, 1995 meeting. Due to BCBS's inability at that time to provide automated reports, no further processes were implemented for presenting monthly reports of potential subrogation cases to the State.

   When BCBS receives a request from an attorney or member to become involved in settlement of an active subrogation case, the file is forwarded in its entirety to the State of Montana Department of Administration who takes control of the recovery. The BCBS log records payments returned to BCBS but does not reflect funds returned directly to the Department of Administration.

2. **Reimbursement Allowances**

   Segal: The impact of reimbursement guidelines relative to nonparticipating providers both in-state and out-of-state should be periodically reviewed to determine the financial impact on employees for utilization of these providers.

State: We concur and will review with BCBS their procedures for setting out-of-state allowances to assure they meet plan objectives. It is also anticipated that BCBS will enter into reciprocity agreements with other state BCBS companies to allow members who need out-of-state services to protect themselves against out-of-pocket costs and help control plan costs.

Resolution: Accident and Sudden and Serious claims for non-participating providers are priced at participating allowances effective September 1, 1993.

Effective March 1994, BCBS began participating in the nation wide ITS processing system. This system allows BCBS of Montana to realize savings from other state BCBS preferred provider and discounted hospital arrangements. These savings are then passed on to the member and State.

In their October 25, 1996 report response, the State clarified additional guidelines that have been implemented to address this concern. For all in-state and out-of-state emergency and accident claims (Class Codes 7 and 27, by non-participating providers), if the difference between charge and allowance is less than $100, charges are allowed. If the difference is $100 or more, pricing is set at the 90th percentile MDR of ZIP code in which services were provided. This is coded for walk-in clinics, critical care physicians, emergency medical physician, emergency room multiple doctors billed by hospital, rural health clinics, and medical assistance facilities. All other related services on the same day are paid the same way. The goal of this policy is to limit out-of-pocket costs where there is no choice of the professional provider.

3. **Reports**

Segal: BCBS should continue to provide guidance to the State in understanding current reports and reliability of this data. Detailed updates regarding the new reporting system should be regularly provided to the State.

State: We concur with this recommendation. The absence of reliable reports precludes adequate program evaluation and needs to be remedied as soon as possible.

Resolution: In April, 1996, BCBS presented their standard format for the 1994 and 1995 Annual Reports to the State of Montana. BCBS notes the State has not indicated difficulty in retrieving necessary data from these reports.

4. **Eligibility Discrepancies**

Segal: BCBS should suspend claims processing on all participants who appear on their monthly discrepancy list until such time as the State reconciles the report or determines appropriate coverage. It is imperative that the State review monthly discrepancy lists without delay.

A complete data coverage reconciliation should be conducted at the time the State's new benefits computer system goes into effect with special emphasis on self-pays; verification should be continued on a quarterly basis.

State: Standard procedure calls for immediate termination of coverage for deletes identified from the certification tape. The new on-line eligibility computer system which internally reconciles premium payment, coverage periods and coverage type should eliminate the discrepancies uncovered in the previous review period. BCBS will process claims exclusively off a system-generated certification tape and updates.

The State was completing a reconciliation at the time our prior report was reviewed. Verification checks were to be conducted at least quarterly during the first year to assess system operation.

Resolution: The process BCBS follows to reconcile the State of Montana eligibility discrepancies has not changed since the last audit period. BCBS indicates that responses from the State of Montana still result in time delays.

The State's October 25, 1996 draft response indicates the BCBS "discrepancy list" processing has changed considerably since the State changed to a new computer system on September 1, 1994. BCBS is notified of all current coverage via the State's eligibility tape. Since BCBS no longer receives and independently enters coverage data, coverage discrepancies no longer exist between State coverage information and BCBS coverage information. All information on coverage and premium collected is reconciled internally within the State Insurance System before being transmitted to BCBS. Most of the questions presented by BCBS are to clarify their edit reports, to be able to accurately enter manual changes into their system, so coverage reflects that on the State's tape. Other questions involve birth dates that do not match those received from a provider on a claim, or a missing primary care physician codes. Many of these questions come from BCBS per phone, and are answered at that time. If information is needed from a member, the State forwards it to BCBS as soon as the member responds. The State is scheduling a meeting with BCBS to discuss the State tape processing and edits, so both parties are clear as to their roles and responsibilities.

Segal: Segal and BCBS agree that the new system implemented by the State in September, 1994 adequately addresses eligibility payment errors; however, other discrepancies can cause participant inconvenience and delay in claims payment. Segal recommends a review of all pertinent data that should be included for BCBS on monthly tape transfers to assure that all required fields are completed. The goal should be to reduce the need for manual intervention by either BCBS or the State through optimum use of system transfer capabilities.

5. **Premium Billings**

Segal: The State and BCBS should review procedures to ensure that the number of participants indicated on the State's billing of administration fees agrees with the number of participants in BCBS files.

State: The State concurs if BCBS feels it is necessary or desirable to assure the State is complying with contract terms.

Resolution: BCBS was in the process of completing a reconciliation at the time the last audit report was presented.

6. **Hospital Discount Arrangements**

Segal: BCBS is encouraged to revise provider arrangements that allow for reimbursement of otherwise ineligible Plan expenses. The employee should be made wholly responsible for noncovered expenses.

State: The State concurs with BCBS response that the participant would be responsible only for the discounted billed charge of the denied service. This would be a benefit to the participant and does not adversely affect the Plan in any way.

Resolution: BCBS now indicates that the documented response to the previous audit was incorrect. All non-covered expenses should be excluded prior to the calculation of applicable discounts and benefit payment.

7. **Injections**

Segal: Provider charges for injectable drugs are currently paid under the prescription benefit code and subject to the lesser coinsurance level for brand name drugs. We find this inconsistent with industry standards.

State: The State understands that BCBS asks providers to bill administration fees separately from the drug fee to determine eligibility of the administration fee.

While that appears appropriate, effective September 1, 1994 BCBS will no longer process the prescription fee under prescription drug benefits as those have been carved out into a separately administered plan. We will work with BCBS to determine how the remaining prescription fee will be processed.

Resolution: As of September 1, 1994, injectable drugs are payable at regular plan benefits, the same as an office visit or administration fee.

8. **Mental/Nervous ICD-9 Codes**

Segal: It is imperative that the State provide immediate response to BCBS inquiries in this matter. A report was sent to the State in April, 1993 requesting instructions for handling payment errors identified through review of covered ICD-9 diagnosis codes. The State did not respond, therefore, recovery of overpayments was not pursued.

State: The State concurs with this recommendation; however, they have no record of receiving the April, 1993 report. Since the audit, a copy was obtained and instructions provided to BCBS for recovery.

Resolution: BCBS reviewed this case and requested the overpayment refund.

9. **Prescription Drugs**

Segal: Brand name drugs should continue to be processed with a 20% coinsurance differential (after stop loss) to realize the full effect of this cost containment measure.

Take home drugs provided upon discharge from a hospital confinement should be isolated from inpatient expenses and paid as prescription expenses subject to the lower coinsurance level (70% brand versus 75% inpatient).

State: The State agrees in principle; however, BCBS's system is not capable of applying coinsurance differentials to only those brand name drugs where the

member has a choice of generic substitution. Continuing the differential indefinitely under this circumstance would be unnecessarily punitive.

The State has no problem with the take home drug theory, however there will be no medical plan benefit with the prescription carve out. We will explore this further with BCBS.

Resolution: The new prescription drug plan effective September 1, 1994 resolved the coinsurance issue for brand name drugs. Take-home drugs remain payable under the regular benefit schedule of 75%.

10. **Overpayment of Benefit Year Maximum**

Segal: A specific claim exceeded plan limitations. Claims history should be reviewed to determine the amount of overpayment and a refund requested.

State: The State concurs with the recommendation.

Resolution: BCBS reports the adjustment was initiated.

11. **System Edits**

Segal: BCBS should utilize full system capabilities for detection and recording of fragmented or unbundled expenses.

BCBS should utilize full system capabilities to track physicians charging multiple new patient exams in order to obtain a greater benefit for established patients.

BCBS should review the system's data base to determine that multiple surgical procedures are being adjudicated correctly.

The out-of-state threshold of $300.00 should be expanded to include investigation of those claims which are not assigned for provider payment.

State: The State concurs with all four recommendations, and is pleased that BCBS indicated in their response that they are pursing them.

Resolution: The lab unbundling project was reviewed periodically in the past two years and a number of ideas were researched, most of which were not cost-effective. BCBS will be actively looking for vendors and bundling software during this next year and analyzing the cost benefit to our claims processing and group utilization experience.

BCBS's current system does not track new patient exams. There is no indication that this is under future consideration.

BCBS has continued to review system edits for multiple surgical procedures during the past two years.

BCBS reports their system has always suspended out-of-state non-assigned claims over $300.00 for review.

12. **Workers' Compensation**

Segal: Until such time that a cost effective automatic transfer of data is made available to BCBS, the State should provide BCBS with an annual report of all work injuries. BCBS could then place appropriate notations in their claims system for identification of potential work related claims that require additional investigation and/or denial.

State: The State concurs with this recommendation.

Resolution: Segal has no information that this recommendation has been implemented.

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SECTION VII - BCBS SUMMARY AND RECOMMENDATIONS

Accuracy Levels

As noted in the main body of this report, our findings are as follows:

- Financial accuracy of 99.69% meets minimum industry standards of 99%.
- Accuracy levels for the total number of claims without error (95.95%) is within industry expectations.
- The 1992-1994 review consisted of three separate audit periods; the most recent period was January 1, 1993 through February 28, 1994. The results of this 1994-1996 audit period reflects a higher level of financial accuracy (99.69% compared to 98.9%). While processing accuracy is within industry standards, it is lower than the 99.6% illustrated in the previous audit period.
- Our review of administrative procedures found BCBS's guidelines to be appropriate and within general industry standards. Based on our claims sample, these procedures are used consistently by BCBS staff.

Turnaround Time

The analysis of turnaround time reflects that 87.46% of all claims were processed within 10 business days. Based on the limited size of our sample (200 claims), this is slightly below industry standards of 90%-95% to be processed within 10 business days or 14 calendar days.

Recommendations

1. **Review of Service Team Efficiency**

   Segal BCBS's Internal Audit Department is in the process of preparing for their initial audit following establishment of Service Teams. We encourage BCBS to share their findings with the State. (Page 7)

   BCBS Blue Cross and Blue Shield of Montana will provide a summary report of their audit findings to the State of Montana.

   State The State concurs with this recommendation.

2. **Subrogation/Third Party Liability**

Segal The State and BCBS should revisit their October 12, 1995 discussion to ensure that all subrogation claims activity is tracked and reported on a regular basis. The purpose of these reports is two-fold: 1) to provide accurate record of monies recovered on behalf of the State, and 2) to advise the State of possible cases that may warrant pursuit of recovery. We recommend the State implement the 6-month trial basis proposed in their response to our prior report. (Pages 10, 13 and 23)

BCBS Blue Cross and Blue Shield of Montana concurs with this recommendation. A monthly report is being developed to provide data on savings and recoveries by subscriber. This report will be available by fourth quarter 1996.

State The State concurs with this recommendation. A report will be generated for BCBS indicating the monies recovered on behalf of the State of Montana.

Segal In addition to implementing the reports on savings and recoveries, Segal recommends that BCBS provide the State with information on cases that may warrant pursuit of recovery by the State.

3. **Reports**

Segal It is unclear whether the concern over claims data reports was resolved since our last audit report. The State relies on such data for program evaluation; therefore, it is critical that the format meets the State's requirements. BCBS should contact the State to discuss and identify any additional State requirements that have been provided in the standardized format. (Pages 11 and 24)

BCBS Blue Cross and Blue Shield of Montana has provided and discussed these reports with the State. Any comments concerning these reports would be welcomed.

State The State concurs with this recommendation. BCBS has provided more detailed and reliable reports at our request, and has agreed to modifications.

4. **State Review of Eligibility Discrepancies**

Segal Delays in the State's review of eligibility discrepancies can result in payment of participant claims past the termination date of coverage. The State should review their current procedures to assure eligibility edits identified by BCBS are researched and returned to BCBS within 5 work days. (Pages 13 and 25)

BCBS Blue Cross Blue Shield of Montana concurs with this recommendation.

State Under the current eligibility tracking system it is not possible for BCBS to pay claims on a member past their termination date, providing BCBS is loading the State tape accurately. Since September 1994, all terminations are processed by BCBS directly from the eligibility tape. Because of the new process, the "discrepancies" BCBS identifies are not usually related to coverage; they are most likely birth date or sex inconsistencies or missing primary care physician codes, none of which would result in claims payment past the termination date.

Segal In revisiting this concern with BCBS, Segal and BCBS agree that errors of termination are not likely to happen with the State's new reporting procedures. The concern is for the delay in claims payment that can result from missing eligibility information. There is also the factor of participant inconvenience to be considered. An example would be difficulty in accessing a provider when the participant's ID card cannot be issued because the primary care physician code was missing from the State tape data.

5. **Retroactive Eligibility Status Changes**

Segal BCBS should review their procedures for the identification of retroactive changes in eligibility status. These procedures should require prompt notification to the appropriate service team so that claims can be adjusted when necessary. (Page 19, worksheet 18)

BCBS These procedures have been reviewed and determined to be adequate by Blue Cross and Blue Shield of Montana Internal Audit staff.

State Although retroactive changes do not occur very often, they need to be processed as consistently and promptly after they are identified so claims adjustments can be made if necessary. The State is not aware of problems associated with retroactive claims adjustments.

6. **Emergency Room Expenses**

Segal System edits for covered emergency room charges, based solely on the hospital's primary diagnosis, should provide consideration for the type of treatment rendered (*i.e.* revenue codes for extensive laboratory and surgical expenses). Current edits resulted in the denial of a sampled claim we feel may have met BCBS's written definition of medical emergency had the claim been submitted to medical review. (Page 19, worksheet 77)

BCBS Blue Cross and Blue Shield of Montana acknowledges that on an occasional basis, claims that should be covered are denied because of the way they are submitted. The Benefits Administration Committee is in the process of evaluating the way in which the system adjudicated emergency room services. They are reviewing emergency

room claims denied and adjusted due to the medical emergency classification. The Committee will then have a recommendation on how to better adjudicate these claims.

State The State concurs with this recommendation and looks forward to BCBS's recommendation. Currently, when emergency room claims are denied, because of the way in which it was submitted, (*i.e.*, without a sudden and serious diagnosis code) corrections are only made for members who appeal the denial (assuming it meets the sudden and serious criteria).

7. **Hospital Ancillary Expenses**

Segal Prior to September 1, 1996, inpatient durable medical equipment expenses were paid at a reduced benefit level without further review of appropriate revenue classification. Eligible ancillary charges for two claims identified in our review were reimbursed at the lower level. The State and BCBS should discuss whether these claims will be adjusted based on current processing guidelines. (Page 19, worksheets 106 and 156)

BCBS Blue Cross and Blue Shield of Montana concurred with this recommendation in their September 30, 1996 report response. However, in a correction dated October 28, 1996, BCBS states that DME benefits are being processed in accordance with the State of Montana HMO benefits. As the lower payment level for durable medical equipment on inpatient hospital bills applies to the HMO subscribers only, any action needed on this recommendation would need to be outlined by the State.

State Prior to September 1, 1996, this only occurred with subscribers on the HMO plan. The current processing guidelines will treat all inpatient DME expenses the same regardless of what medical plan the member has chosen. A meeting will be scheduled with BCBS to discuss disposition of the two claims identified.

8. **Hospital Primary Diagnosis Edits**

Segal Eligible equipment and services are determined by LRSP system edits based on primary diagnosis codes submitted by the hospital. BCBS should establish a threshold (*i.e.* $250) whereby claims can be suspended for review of additional reported diagnosis that may substantiate medical necessity. (Page 20, worksheet 178)

BCBS Eligible equipment and services are not determined solely by diagnosis. Many factors are considered before payment determination is made. Many cases are reviewed, as in the case of the air fluidized bed.

State In light of BCBS's response we will determine the factors considered and review the need for other criteria.

Segal Based on clarification from BCBS regarding audit worksheet #178, page 20, we concur with the State's decision to determine appropriateness of current factors used by BCBS and the possible need of additional criteria for suspending certain equipment charges to determine medical necessity. Consideration should be given to financial impact to participant's when an item (*e.g.* costing $1,080.00) is provided by the hospital and subsequently determined to be ineligible and denied by BCBS.

9. **Unbundling and Upcoding Edits**

Segal Unbundling and upcoding has been identified as a provider practice to maximize benefit reimbursements. Similar to BCBS procedures for identification of unbundled surgical procedures, we feel additional system edits could be developed to identify certain services that should be subject to review prior to payment. For instance, all new patient codes and individual tests that should be classified as multi-channel laboratory services can be flagged by CPT code.

Standard insurance industry guidelines require automated or manual detection of unbundled and upcoded services. We have found that most major insurance carriers and third party administrators utilize purchased or company developed software for this purpose as a routine administrative service. (Page 28)

BCBS The lab unbundling project was reviewed periodically in the past two years and a number of ideas were researched, most of which were not cost-effective. We will be actively looking for vendors and bundling software during this next year and analyzing the cost benefit to our claims processing and group utilization experience.

State The State concurs with this recommendation.

10. **Workers' Compensation**

Segal Our prior report recommended that the State provide BCBS with reports of all work injuries. BCBS could then place appropriate notations in their claims system for identification of potential work related claims that require additional investigation and/or denial under the State's medical plan. We received no indication that this recommendation was implemented or discussed with BCBS. (Page 29)

BCBS N/A

State This recommendation was implemented effective September 1, 1996. A monthly report is generated and sent to BCBS for identification of possible duplicate claims payments.

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SECTION VIII - BCBS RESPONSE

BlueCross BlueShield of Montana

An Independent Licensee of the Blue Cross and Blue Shield Association

3360 Tenth Avenue South
P.O. Box 5004
Great Falls, Montana 59403
(406) 791-4000
Fax: (406) 727-9355

Customer Information Line:
1-800-447-7828

September 30, 1996

Carol S. Hoel, Claims Auditor
5080 North 40th Street, Suite 400
Phoenix, AZ 85018

RE: State of Montana

Dear Carol:

We have reviewed the State of Montana audit report. The information provided in this report is accurate with the following exceptions:

1) To clarify the situation explained for Worksheet 178 (page 19), all air fluidized beds suspend for review. The claim selected for audit was reviewed to determine the medical necessity of the air fluidized bed.

2) Please reword the first paragraph under Resolution stated on page 27 to:

   The lab unbundling project was reviewed periodically in the past two years and a number of ideas were researched, most of which were not cost-effective. We will be actively looking for vendors and bundling software during this next year and analyzing the cost benefit to our claims processing and group utilization experience.

Listed below are the responses of Blue Cross and Blue Shield of Montana to the State of Montana audit recommendations:

1) **REVIEW OF SERVICE TEAM EFFICIENCY**
   - Blue Cross and Blue Shield of Montana will provide a summary report of their audit findings to the State of Montana.

2) **SUBROGATION/THIRD PARTY LIABILITY**
   - Blue Cross and Blue Shield of Montana concurs with this recommendation. A monthly report is being developed to provide data on savings and recoveries by subscriber. This report will be available by fourth quarter 1996.

3) **REPORTS**
   - Blue Cross and Blue Shield of Montana has provided and discussed these reports with the State. Any comments concerning these reports would be welcomed.

4) **STATE REVIEW OF ELIGIBILITY DISCREPANCIES**
- Blue Cross and Blue Shield of Montana concurs with this recommendation.

5) **RETROACTIVE ELIGIBILITY STATUS CHANGES**
- These procedures have been reviewed and determined to be adequate by Blue Cross and Blue Shield of Montana Internal Audit staff.

6) **EMERGENCY ROOM EXPENSES**
- Blue Cross and Blue Shield of Montana acknowledges that on an occasional basis, claims that should be covered are denied because of the way they are submitted. The Benefits Administration Committee is in the process of evaluating the way in which the system adjudicates emergency room services. They are reviewing emergency room claims denied and adjusted due to the medical emergency classification. The Committee will then have a recommendation on how to better adjudicate these claims.

7) **HOSPITAL ANCILLARY EXPENSES**
- Blue Cross and Blue Shield of Montana concurs with this recommendation.

8) **HOSPITAL PRIMARY DIAGNOSIS EDITS**
- Eligible equipment and services are not determined solely by diagnosis. Many factors are considered before payment determination is made. Many cases are reviewed, as in the case of the air fluidized bed.

9) **UNBUNDLING AND UPCODING EDITS**
- The lab unbundling project was reviewed periodically in the past two years and a number of ideas were researched, most of which were not cost-effective. We will be actively looking for vendors and bundling software during this next year and analyzing the cost benefit to our claims processing and group utilization experience.

10) **WORKERS' COMPENSATION**
- N/A

We would like to take this opportunity to thank you and Kim Keenan for the professionalism and courtesy extended to us during this audit.

If you have any questions about the information in this response, please contact us.

Sincerely,

Peg Hasner
NMIS Coordinator

Karl Kreiger
Internal Auditor

021PHC03.1C

BlueCross BlueShield of Montana

An Independent Licensee of the Blue Cross and Blue Shield Association

3360 Tenth Avenue South
P.O. Box 5004
Great Falls, Montana 59403
(406) 791-4000
Fax: (406) 727-9355

Customer Information Line:
1-800-447-7828

October 28, 1996

Carol S. Hoel, Claims Auditor
5080 North 40th Street, Suite 400
Phoenix, AZ 85018

RE: State of Montana

Dear Carol:

The purpose of this letter is to further clarify the information provided for Audit Recommendation #7 - Hospital Ancillary Expenses. First, the lower payment level for durable medical equipment on inpatient hospital bills applies to the HMO subscribers only. The traditional State of Montana benefit plan pays DME (regardless of the place of service or provider) at the same benefit level as all other medical services. The benefit information for the HMO State subscribers states that DME is paid at 80 percent and the copayment is not credited toward the maximum member liability amount. Blue Cross and Blue Shield of Montana processes DME under this payment level regardless of the provider or place of service.

In addition, at the time of the audit, the benefit coding area of Blue Cross and Blue Shield of Montana notified us that this payment level on DME would change September 1, 1996, for the State. Based on information provided to us from the State, the DME benefit is not changing. Therefore, Blue Cross and Blue Shield of Montana would not concur with this recommendation. We (Blue Cross and Blue Shield of Montana) are processing the DME benefit in accordance of the State of Montana HMO benefits. Any action needed on this recommendation would need to be outlined by the State.

I apologize for any inconvenience we may have caused you or the State of Montana.

Thank you.

Sincerely,

Peg Hasner

Peg Hasner, NMIS Coordinator

021PHC28.1C
cc: Larry Tobiason, State of Montana

SECTION IX - GENERAL CASE MANAGEMENT SERVICES

To assist in understanding the case management audit findings and recommendations, we have provided a general introduction to case management services including definition of case management, goals of utilization management and components of an effective utilization management organization.

Case Management as a Component of Utilization Management

Every organization that provides or pays for health care is under pressure to ensure that patients receive the most appropriate and cost-effective services possible. The four key elements to health care cost control include: plan design, discounts, utilization management and proper claims adjudication. Problems with any one of these four key areas will often cause a health plan to be out of control.

Utilization management (UM) is just one of the techniques to controlling health care costs. Various approaches are used to control services including review of services *before* they are rendered (precertification), review of services *while* they are being rendered (concurrent review) and assessment of services *after* they have been rendered (retrospective review). In addition to these, there is a level of detailed involvement in patient management, commonly referred to as case management. Case management is simply one of the variety of tools the UM firm employs to control health care costs.

The primary **goal of utilization management** is to manage health care by determining the necessity, appropriateness, and efficiency of health care services rendered to plan participants. Medical necessity refers to the proven need for intervention to improve or preserve health, while appropriateness refers to the selection of health care alternatives which are determined to be the most effective for the individual, considering their circumstances.

Case management is typically an administrative service that directs the patient through a series of phased involvements with health care services over a period of time, coordinating the caregivers, physicians, vendors, payor and patient to achieve quality, cost-effective health care. Case management should match the needs of the patient with appropriate treatment resources. This type of management involves an assessment of the proposed plan of care as necessary, appropriate and cost-effective with appropriate recommendations, as well as redirection of the patient toward an existing discount network arrangement or negotiating with the health care vendor for rates which are less than billed charges.

Case management is unique in that the universe of possible patients is scrutinized to identify and target energy toward the small percent of the population who may account for a large portion of the health care dollars. Thus, the case manager's primary goal should have dual emphasis: to protect the plan from financial abuse by patients and health care providers who may waste services, over utilize benefits, have poor planning, ill-conceived treatment plans, unrealistic goals and personal

financial motivations for treatment options, while assuring that the patient is cared for in the quickest, safest and most accurate manner. This approach combined with a talent for the design of creative, cost-effective treatment plans, makes for a financially sound and patient satisfying experience.

While the majority of employers want case management to be a cost-containment service, there are times when case management recommendations can have the opposite effect and increase the cost of patient care. These situations should be rare. Savings from case management should demonstrate that without the UM firm's involvement, the patient's case would have been more costly. Good business sense dictates that the cost of providing the case management services should not exceed what one reasonably expects to save in hard dollars. You should be able to audit and verify true savings from case management.

Components of Effective Utilization Management Organizations

There are certain components associated with successful utilization management programs. "Successful" means that these utilization management organizations demonstrate that they can actually manage care. The term "manage care" is an action word which indicates that the UM organization *controlled* something. In fact, the original term for medical management was Utilization Review, which has since been replaced by utilization management. This is because the term "review" is viewed as passive, to watch something, and does not reflect the appropriate image.

In order for a utilization management organization to actually control care and direct or redirect the care toward an effective, appropriate and cost-efficient goal, certain key operational components must be in place. These include, but are not limited to the following:

- **Knowledge and experience of the non-physician advisor**

  The main purpose of the non-physician advisor (*e.g.*, RNs, LVN/LPNs) is to screen cases for referral to a physician advisor. For consistency in review decisions, most utilization management organizations use screening criteria to assist their staff in gathering organized and accurate data about the necessity and appropriateness of a service. Criteria also encourages consistency, reducing variation in decision-making among review staff.

  Most published written screening criteria has been developed for use by health care professionals who have several years of clinical practice. It is difficult for non-medical persons to understand the medical jargon and information they are receiving and compare it against medical criteria. Not only is it important that the person using the criteria have a clear understanding of why they are to ask certain questions, but there is also an issue of credibility in the communication that occurs between medical professionals during the process of case review. Mismatches in the knowledge and experience between reviewer and provider can account for both inappropriate approvals and inappropriate referral of cases to a higher level of physician review, which increases cost to both the UM program and the plan.

- **Depth and objectiveness of screening criteria**

  This refers to written criteria used by non-physician advisors to determine which cases should be referred to a higher level of review before the service is approved. Ideally, screening criteria and non-physician reviewer skills should cause at least 20% of the reviewed cases to be forwarded for physician advisor analysis.

  Non-existent or poorly written criteria are ineffective. Examples would include criteria which rely on subjective symptoms such as "pain" or "significant bleeding" and which cannot be substantiated, or is open to interpretation such as "abnormality in radiographic findings".

- **Knowledge and experience of the physician advisor**

  It is wise from both a legal and medical standpoint to have all adverse review recommendations made by physicians, not by non-physician personnel. The physician-to-physician process, called peer review, maintains credibility, especially when review decisions are challenged. Cases sent to the physician advisor are often not subjected to another layer of written screening criteria as reference, but instead rely upon the expertise, objectivity and creativity of the peer review physician.

  The level of peer review is important, as mismatches in peer review can be just as detrimental to the review process as mismatches in non-physician advisors. The level of peer review refers to how closely the reviewing physician matches the requesting physician in terms of the field of expertise and practice. For example, a dermatologist advisor will not be nearly as effective as a neurosurgeon in discussing a requesting surgeon's necessity for a spinal fusion or the need for inpatient rehabilitation confinement. Matching the clinical specialty of the reviewing and requesting physician is critical to making accurate review decisions.

- **Reviewer confidence and tenacity**

  These qualities apply both to the non-physician reviewer and, more importantly, to the physician advisor. It is ineffective when a truly unnecessary situation is accurately screened by the non-physician reviewer only to be overridden by a weak physician advisor. All levels of reviewers should be comfortable with handling resistance from requesting health professionals and be skilled in defusing angry professionals while tactfully suggesting and negotiating alternate plans. It is often helpful to converse with professionals in terms of outcome of actions, referring to published literature where appropriate.

- **Innovation and problem-solving skills**

  Crucial to successful case management is effective design of a plan of care which is more cost-effective and creative than that plan proposed by the existing health care team. This can be as simple as redirecting the patient and health care team toward a PPO vendor instead of using a non-contracted vendor or as complex as redesigning a plan of home care where

numerous family and friends will learn to provide ventilator care obviating the need for ICU qualified home nursing care.

Characteristics of highly skilled and truly valuable case managers include:

- Knowing the subtleties of the patient's benefit plan booklet;
- Understanding the clinical issues of the patient's disease;
- Learning the capability and response time of health care vendors;
- Possessing an awareness of community resources to deal with the patient's social and financial issues;
- Being organized;
- Maintaining an assertive communication style;
- Developing an investigative mind; and
- Learning to "think outside the box" (innovation and creativity).

SECTION X - VRI OVERVIEW OF SERVICES PERFORMED

Vocational Resources, Inc. (VRI) is a wholly-owned subsidiary of Blue Cross and Blue Shield of Montana. Their primary office is located in Billings, Montana. Prior to the fall of 1994, Blue Cross and Blue Shield performed the UM services for the State account. Thereafter, a decision was made, between Blue Cross and VRI, to transfer all UM services to their VRI subsidiary. Several Blue Cross UM employees were also transferred to VRI in the change. VRI acquired Managed Care Montana in November of 1994.

VRI is not credentialed by Utilization Review Accreditation Certification (URAC), a common voluntary, quality accreditation organization. According to VRI, they "considered applying for certification with URAC and to that end completed a preliminary draft application utilizing a URAC consultant. This URAC application was not filed once it became known VRI would need to meet standards for the National Committee for Quality Assurance (NCQA)." NCQA is also a voluntary quality accreditation organization whose efforts have been mainly focused on assuring minimum quality standards within HMOs. VRI indicates that they are "in the process of becoming NCQA accredited." VRI notes that "URAC accreditation is much more narrow in focus and looks strictly at review procedures, staff credentials, policies and processes" of utilization management firms primarily. VRI indicates that "NCQA also reviews those elements but looks additionally at outcomes that surround consistency, prevention, quality management and improvement."

Certification and accreditation does not, however, address the effectiveness of any UM firm's review activity.

Contracted Case Management Services

VRI's contract for the period September 1, 1994 through August 31, 1997, indicates that the purpose of their utilization management program is to assure that:

- employees receive quality, cost-effective health benefits,
- the employee actively participates in health care decisions by understanding the alternatives available for the most cost-effective care in the most appropriate setting,
- provider participation and treatment planning is maximized to achieve appropriate care and patient satisfaction, and
- management of health care is linked with the highest medical standards and sound business economics.

In the contract between VRI and the State of Montana, VRI agrees to perform the following review services:

A. Type of Services

- Precertification of hospital admissions (Section 1)
- Continued stay review (Section 2)
- Retrospective review (Section 3)
- Case management (Section 4)
- Healthline Patient Assistance Lines (Section 5)
- Psychiatric PPO network (Section 6)
- Focused review proposal (Section 7)
- Appeal process (Section 8)
- Administrative Services/reports,forms,claims interface (Section 9)

B. Fees

The fee for utilization management services, excluding case management, is capitated: $1.15 Per Employee, Per Month (PEPM) year one, $.97 PEPM for year two and $.99 PEPM for year three. Case management, during all three years, is at a uniform rate of $90.00 per hour. Case management travel is reimbursed at $40.00 per hour. There is no access fee for use of the psychiatric PPO network.

C. Specific ICM Services

Highlights of the specific case management services to be performed under the contract include:

1. Identification of cases suitable for case management services and categorization into one of four status as:

   a. appropriate for case management;

   b. appropriate for onsite case management;

   c. flag to be watched; or

   d. rejected.

2. Verification of eligibility.

3. Initiation of the case management process to:

   a. define the goals to be met;

   b. obtain preliminary medical information;

   c. choose onsite or telephonic case management;

   d. outline a preliminary treatment plan as associated cost aversions; and

   e. open the case.

4. Out of state cases are referred to Blue Cross and Blue Shield or a contracted case management firm.

5. The case management process will include:

   a. A RN will be assigned and contact will be made with appropriate individuals associated with the patient's care.

   b. Release of information consent forms will be obtained from the patient or family.

   c. Development of alternative care plans, where possible, that provide quality cost-effective use of medical dollars.

   d. Determine if extracontractual benefits are needed and approved by the State Plan representative. If so, create a written contract and forward to the subscriber, physician, other health care providers, and the State's claims administrator.

   e. Proceed with alternative plans if the State disapproves extracontractual benefits or implement the plan when no extracontractual benefits are needed.

   f. Initiate no more than ten hours of case management services before seeking approval from the designated State Plan representative.

   g. For the duration of the case, VRI will monitor for changes in the medical condition, identify needs and the progress in meeting goals.

   h. Provide quarterly reports regarding case status.

   i. Case management services will stop when the patient dies, goals of the care plan have been met or possibly with rehospitalization.

VRI appears to be complying with a majority of their contract obligations as specified above. Improvement is suggested in the following areas:

- C-1: VRI should produce ongoing reports (*e.g.* quarterly) which detail the number of cases selected for screening followed by an account of the number of screened cases selected for actual case management.

- C-3a: No evidence of goals (short and long term) documented for each case. Articulating goals should help determine if the physician's treatment plan is realistic (*e.g.* is the paraplegic patient really expected to walk again? If so how soon? Thus, is the type, frequency, duration and location for physical therapy appropriate?)

- C-5b: Consider amending the contract to release VRI from responsibility for consent forms, making case management an integral part of the State's medical program, not that it is only possible if the patient/family agrees to be case managed.

- C-5d: If approved by the State, consider limiting the use of extracontractual benefit overrides to both picking up the patient's coinsurance responsibility and adding benefits where the plan design has a fixed limited amount (*e.g.* home health visits, physical therapy dollars, etc.).

- C-i: Consider amending this contract wording such that VRI can stop case management services when it is apparent that although the patient's goals have not been met, no further case management impact is apparent and only case monitoring (not necessarily a cost-saving service) will be occurring.

VRI Organizational Overview

VRI utilizes seven RN's in the performance of their case management services for the State's account. VRI indicates that cases are selected for ICM by a staff member who screens potential candidates from the list of patients precertified. The primary trigger to identify cases is the patient's diagnosis, but age and the number of admissions in the past six months is also considered. Presently their case identification system does not appear to have long length of stay or cases where a certain dollar amount has been expended as triggers for inclusion in case management.

VRI's case managers frequently become involved with fee negotiation for ancillary vendors such as home health, home infusion therapy, durable medical equipment, non-emergency patient transport, therapy services, hospice and rehabilitation facilities. This appears to be a direct result of the fact that there is no designated ancillary PPO for the State account. Blue Cross and Blue Shield indicates that they have hospital and physician discount arrangements in Montana but no other providers under contract.

The State does have an arrangement with Blue Cross and Blue Shield of Montana (BCBS) to act as their claims administrator and to access discount arrangements for inpatient hospital and outpatient physicians fees. Additionally, BCBS has offered discounts for out of state hospital and physician use

via reciprocal arrangements with their Blues association. With the exception of K-1 in the State of Montana medical plan document, language does not clearly indicate incentives (steerage) to encourage plan participants to seek services through a preferred contracted provider. Further, there are no discount arrangements beyond hospitals and physicians, leaving the array of ancillary vendors, home health, hospice, skilled nursing, transportation, etc to bill on a fee for service basis.

VRI has a primary Medical Director, Dr. Steve Johnson, a neurologist, who is available to the nurses onsite in the Missoula office. There are other physician advisors in other specialties who assist the nurses and Dr. Johnson with special case reviews.

Reporting Capabilities

According to Carlotta Hecker, RN, CCM, the Director of Case Management for VRI, prior to November, 1994 and up until June, 1995, the State received quarterly reports listing the savings from case management efforts but not the cost to manage such cases. ICM costs were tallied and billed separately on quarterly invoices. In June of 1995, Ms. Hecker indicates that a new report format was instituted which incorporates both the savings from case management and the case management hourly charges. The report frequency was changed to monthly from the normal quarterly reporting format at this time. Back-up documentation of specific case management efforts is available to the State from VRI, if requested.

In January of 1996, VRI implemented a system to tally individual hours spent on case management separate from travel time and mileage costs. Prior to this time, all costs were totaled and could not be separately identified. Ms. Hecker indicates that VRI bills when the case is open to active case management. Screening of cases to see if the case is a candidate for case management is not billed to the State.

Three reports were available to this auditor:

- ICM monthly cost summary,
- summary of case management time/individual patient, and
- quarterly savings report detailing the individual case savings rationale.

The format for these three reports and the content of the summary of case management time per individual patient is satisfactory. The content of the other two reports should be improved, as discussed below:

- The **ICM Monthly Cost Summary** is formatted in a clear manner. Trend is recognized as the quarters are displayed side by side. Additionally, the "bottom line" savings is displayed as total savings minus the ICM fees for a net savings figure. This is an honest approach to the representation of case management impact. The problem, however, is that this auditor seriously doubts the calculation for savings estimates on individual cases and, consequently the validity of the report is suspect. Of the 25 cases audited, VRI reported total ICM savings

of nearly $467,500; however, documentation in the case files makes it impossible to substantiate this amount.

- The **Quarterly Savings Report** is organized but lacks a section outlining the goals for the patient. The "Treatment Plan/Alternatives" section rarely presents alternatives. Usually what is presented is the plan of action VRI has approved, not the options the State and VRI considered. As presented, this section should more accurately be entitled "VRI's recommendations." Then above this section VRI should present the State with the alternatives which were considered and why VRI settled on the final recommendation.

  For example, if the doctor wanted inpatient rehab but VRI did not believe that the patient's confused mental status would allow learning to occur, perhaps VRI would outline options such as transfer to a skilled nursing facility for therapy with the cost and benefit limits versus home therapy at a certain frequency/duration and benefit limit, versus home with daily visits to an outpatient therapy center and benefit limit. The pros and cons of such a plan can then be viewed by the State to assure that all alternatives have been explored before approval of a recommendation.

SECTION XI - VRI INDIVIDUAL CASE REVIEW

Sample Selection

The auditor selected a total of 25 individual patient cases for the audit. At random, 20 names were identified from a report listing all cases managed from November, 1994 to present and five more names randomly selected from a list of large claims exceeding $100,000 in paid claims for the period September 1, 1994 through November 30, 1995. Several alternate names were selected but not needed as VRI was able to find records on all of the originally selected 25 cases. Additionally, the billing and savings reports corresponding to the 25 cases were also reviewed.

The patients' ages spanned from birth to age 64 and were both male and female. Diagnoses varied as well as the types of services received from hospital care, to emergency room services, home health, home infusion therapy, hospice, rehab and medical equipment. Diagnoses spanned the range from medical to surgical, obstetrics to neonatal and psychiatric.

The information available to the auditor for review was a hard copy print-out of the computer screens documenting the case manager's notes, plus the typed savings and billing invoices. A table outlining these case audit findings is attached to this narrative report. The comments are taken from the documentation in the case management records sent for this audit.

Findings of Individual Case Reviews

VRI's case management services are to be commended for the following:

- Documentation is relatively clean and organized without unfamiliar abbreviations and subjective internal codes.
- The types of cases chosen for case management appear appropriate. About half of the audited cases demonstrate that VRI found the case via precert or their own internal referral system. Only occasionally did the family or vendor initiate the case management.
- The depth of case management documentation appears to be enhanced after 1994 and VRI's takeover of UM services.
- The frequency of contact on the case is good. Contact is sometimes daily, more than daily, but no less than every few days.
- The case managers do not appear afraid to talk directly to the patient or caregiver to get clarity in information.

- Periodic onsite assessment was performed. One case has a patient conference at the hospital which was attended by the case manager. More onsite intervention and data gathering may be appropriate, when travel distance is not an issue.

- With rare exception, the duration of case management appears reasonable.

- Most case managers offered sufficient "TLC" and verbal support to patients and their caregivers. The case managers demonstrate significant emphasis on being an advocate for the patient.

- Able to develop rapport with patients, families and vendors without antagonizing the relationship.

- The new billing system which tracks case management time, in as little as 10 minute increments, looks useful.

- Desire to negotiate fees and call around to find the "best" price on equipment or supplies in the absence of PPO vendors is commendable. The long term solution, though, is to create a defined discount vendor panel for easy access.

There are, however, two key areas for improvement:

- The purpose of case management for the State of Montana needs to be clarified: If the purpose is to enhance benefits and act as an ombudsman for patient rights, then VRI is doing a great job. If, however, the purpose is to save money for the program through creative, timely and cost-effective case management, then VRI needs to rework the emphasis of their case management services.

- VRI and the State need to work together to develop a comprehensive and cost-effective discount contractual arrangement with in-state ancillary vendors (*e.g.* home health, DME, hospice, etc.) as well as commonly used out of state facilities and ancillary vendors. A substantial number of patients travel outside Montana for serious and costly services (*e.g.* to Colorado, Utah, Washington and Oregon). This should eliminate the hours spent researching best prices and negotiating and verifying contracted vendor rates on each individual case.

The following individual case tables detail the auditor's findings and VRI's responses. In identifying the number of months of individual case management, time can involve numerous intermittent case management segments.

Case ID# 1	Age: 19	Diagnosis: Incomplete quad secondary to sports injury
Factor(s) Prompting Case Selection: Hospital called		
Date Case Opened: 4/12/94	Date Case Closed: 10/31/95	# Months in ICM: ~16

Auditor's Original Comments: Monitored care through numerous health care settings. Gave verbal support to parents. Researched best prices for DME. Went onsite. Coordinated bills received with negotiated amount. Patient quickly became independent after injury but ICM stayed on case to monitor progress even after patient went to college. Duration of ICM appears excessive. Patient appears to have exceeded the $2,000 annual outpatient therapy benefit as authorized by ICM.

Savings Realistic? No. It appears that the VRI's savings report cost the State rather than saved, in terms of adding therapy benefits well beyond the plan limit plus the ICM hourly fees.

VRI's Rebuttal to Auditor's Original Findings: There is a 60 day rehab benefit. He chose to go home early and with outpatient therapy it was possible. Admitted 4-1-94. Discharged home around May 21. Used only 33 days. By my review of notes he would have met criteria for Rehab for the entire 60 days. ICM took the 27 days as savings to pay for the outpatient services since policy only covers $2000. ICM claimed $40,000 which figures out to $1481 which is the cost of a day on the unit. You could ask any physiatrist and I believe as long as the patient makes gains they stay on the unit. Considering how young he is he would have stayed 60 days so I believe this was the savings they worked off of for paying outpatient. Care plan was for 4 months so could have closed in Oct of 94.

Auditor's Comments to VRI's Rebuttal: VRI's rebuttal suggests that a savings of 27 rehab days was claimed. There is no information in the record to demonstrate that VRI caused the patient to go home, rather a week before his actual discharge, the notes indicate the patient was anxious to leave the facility. There is no information documented to suggest that had VRI not been managing this case, the patient would have stayed the entire 27 days or any longer than he did stay. *Savings cannot be justified based on the documentation in the medical record.*

Case ID# 2	Age: 4	Diagnosis: Leukemia
Factor(s) Prompting Case Selection: Hospital called		
Date Case Opened: 6/6/94	Date Case Closed: 3/4/96	# of Months in ICM: ~3

Auditor's Original Comments: Worked to get discounts on home health and chemotherapy.

Savings Realistic? No. Cannot validate that the alleged savings from use of home infusion is in lieu of hospital confinement. In each discharge, no evidence home care was VRI's idea. Notes indicate VRI unaware of patient's discharge till home infusion vendor or family called VRI. Insufficient information on pre and post discount arrangements to quantify savings.

VRI's Rebuttal to Auditor's Original Findings: ICM did request home IVs if possible. Dr took suggestion and client discharged on home IVs. Also discounted price from $425 to $324 per day for 5 days. See Notes. Also negotiated Neupogen form $300/day to $200/day.

Auditor's Comments to VRI's Rebuttal: Can find evidence of a negotiated perdiem for certain home IV medications, however, cannot find the original price in order to calculate savings. VRI's rebuttal indicates the savings from their negotiation was approximately $100 per day. The number of days that this savings is applicable toward is, however, not clearly documented. *Auditor remains unable to find documentation in the ICM records to verify the originally claimed saving of $9,279.*

Case ID# 3	Age: 18	Diagnosis: Paraplegic after sports vehicle injury and 1 yr later, an MVA
Factor(s) Prompting Case Selection: Hospital called		
Date Case Opened: 5/20/94	**Date Case Closed:** 7/18/95	**# of Months in ICM:** ~ 6

Auditor's Original Comments: Approved a plan of care where the $2,000 outpatient therapy benefit appears to have been exceeded. Appears to have received two separate rehab confinements — one for 51 days at $56,000 and another for one month at an unknown cost.

Savings Realistic? No, cannot understand where savings of $4,465.47 came from. Patient appears to have exceeded inpatient and outpatient rehab limits and home health. This cost the State, not saved the State, plus the ICM fees.

VRI's Rebuttal to Auditor's Original Findings: Patient had 60 day benefit. Did use 51 days on first admit. Was discharged because could not do more rehab while in body jacket. Plan was to discharge until jacket removed and readmit to complete rehab. Medical Director at that time Dr. Maher, tried to get patient back to Montana but mother would not agree. Cost savings realized on wheelchair. Original price $3402. Negotiated to $2675. Home health was deducted from regular benefit. Medicaid eventually approved and part of second admit covered by Medicaid. Later admit was following MVA. HH ordered but went through regular benefits.

Auditor's Comments to VRI's Rebuttal: There are notes on 7/5/94 which indicate that VRI spoke with a person named Ellen McGruff about a price quote of $3,402. There is no information to suggest what equipment that price is related to. There is another note on 7/7/94 regarding a telephone call from Apex indicating an approximate cost of $2,675 which, again, does not indicate the equipment applicable to this price quote. It is not clear whether or not Ellen McGruff and Apex are the same organization or show that VRI was shopping for best prices. *In either scenario, there is documentation of a savings of $3402 minus $2675 or $727. Thus $727 of the originally stated $4,465 savings can be substantiated by the documentation in the record.*

Case ID# 4	Age: 1	Diagnosis: Leukemia with bone marrow transplant
Factor(s) Prompting Case Selection: Hospital called		
Date Case Opened: 3/24/94	Date Case Closed: 10/24/94	# of Months in ICM: ~7

Auditor's Original Comments: Tried to negotiate discounts for home care and meds without success.

Savings Realistic? No, cannot explain $39,892 savings from documentation.

VRI's Rebuttal to Auditor's Original Findings: Did get cost negotiated on TPN. Because of ICM, mixed TPN was used while inpatient instead of wasted. Goal in this case was to extend transplant benefits by getting best prices for supplies and try to provide as many services on outpatient basis as possible. Benefit was eventually used up and child went on Medicaid.

Auditor's Comments to VRI's Rebuttal: The notes do indicate on 3/30/94 a rate of $295 for TPN services and on 3/31/94 a rate of $175 for TPN services. It is unclear whether this is from the same home health agency or different agencies. Assuming that VRI accepted the $175 rate, this would represent a $120 per liter savings, whether by fee negotiation or by price shopping for the home health vendor with the lowest prices. However, there are *no notes to demonstrate how many liters the patient received and, consequently, savings cannot be verified from the ICM records.*

Case ID# 5	Age: 27	Diagnosis: Severe diabetes affecting stomach, intestines, kidneys, eyes and heart
Factor(s) Prompting Case Selection: Appears to have been selected by VRI due to frequent admissions		
Date Case Opened: 12/93	**Date Case Closed:** 1/96	**# of Months in ICM:** ~24

Auditor's Original Comments: Documentation does not demonstrate that VRI proposed care which the patient and health team had not already planned. Tried to coordinate home health visits with patient and family's wishes. Tried to negotiate discounts on home health and equipment with unknown success as pre and post negotiated fees not well documented.

Savings Realistic? No, appears to have exceeded home health visit limit. ICM did not deter the frequency of inpatient use. Was admitted numerous times in the two years ICM followed this case.

VRI's Rebuttal to Auditor's Original Findings: This is a very long involved case as you noted. This individual was very ill during the entire case. In reviewing the [notes], it is apparent to me that without the relationship she developed with case management, she would have been hospitalized many more times than she was and would have met criteria. Due to length of case notes I will not resubmit just ask that you review closely for criteria and I know you will find that she could have been in several more times but outpatient services were offered to her which she took.

Auditor's Comments to VRI's Rebuttal: VRI indicates their savings is related to the relationship that the case manager established with the patient. *Auditor cannot find that the ICM records support this information or the estimated $182,898 savings.*

Case ID# 6	Age: 46	Diagnosis: Lumbar spine osteomyelitis and diabetes
Factor(s) Prompting Case Selection: Via VRI's concurrent review		
Date Case Opened: 10/3/94	**Date Case Closed:** 11/22/94	**# of Months in ICM:** ~ 1½

Auditor's Original Comments: Coordinated with State to approve custodial care (an excluded benefit) in form of a personal care attendant $40/wk for 8 weeks or $336. Tried to negotiate discounts on home health and drugs with unknown success as pre and post negotiated fees not well documented.

Savings Realistic? No evidence that home IV was in lieu of 56 days of inpatient confinement. The days are gone when patients can be admitted purely for IV antibiotics. It is nearly always an outpatient service. Thus, hospital admit would have been an option.

VRI's Rebuttal to Auditor's Original Findings: ICM introduced idea of home IVs. A perdiem for antibiotics was arranged at $152/day. In the end, client wouldn't sign extracontractual agreement and all services went through regular benefits. Cost savings occurred when bills were submitted for the perdiem of antibiotics which was less than the insurance company would have paid if negotiations had not occurred. Aide was going to be paid through ICM as not a covered benefit yet cheaper than RN.

Auditor's Comments to VRI's Rebuttal: No evidence in notes to suggest that home IV antibiotics was VRI's idea. Notes indicate that on 9/23 that "Dr. Grier anticipates discharge around 9/26/94." No information about original fee-for-service price for home antibiotics, thus, not possible to calculate savings that a $152 perdiem produced. No evidence that use of a non-skilled home health attendant was a savings to this case.

Note: Montana's plan document is confusing in that home health aides ARE a covered benefit on page 54 under L-28 Home Health Services yet Customer Services told VRI they were not covered. Also, the kinds of services an aide is allowed to perform (comfort, hygiene, convenience) are excluded on page 62 under M-32. *Rebuttal from VRI does not alter auditor's original findings that there is a lack of documentation to support originally stated savings.*

Case ID# 7	Age: 19	Diagnosis: Cervical fracture after fall
Factor(s) Prompting Case Selection: Via VRI's concurrent review		
Date Case Opened: 10/3/95	Date Case Closed: 11/27/95	# of Months in ICM: ~ 1½

Auditor's Original Comments: Followed doctor's orders and family requests for home care and DME. Seemed to negotiate some fees but pre-negotiated prices not documented.

Savings Realistic? No. Cannot validate that the savings from a hospital bed at home was in lieu of a nursing home stay. Do not find doctor's request for nursing home in notes.

VRI's Rebuttal to Auditor's Original Findings: When ICM met with the client and family they initially requested a hospital bed. You will note in documentation that the nurse suggested they try their bed at [home] since it's not usual for a hospital bed to be needed for this condition. Notes do indicate the client tried his waterbed and daybed, both of which were not tolerable. A rate was then negotiated on the bed from $148 to 115. I have underlined this. Also in the nurse's judgment a skilled nurse was set up to check on this patient due to complaints of blurred vision, laceration on eyebrow and unstable due to halo brace. When the nurse went out she called ICM with [pus in] laceration, which she cleaned, suture removal at no extra cost, identified sore under sheepskin of halo brace support. Early identification of the sore resulted in the ICM nurse contacting the treating Dr.in Billings to see if a local Dr. could evaluate the fit of the halo, address the pressure sore, and check pin sites. This was done and approval given. ICM contacted the mother of the client to set up an appointment with regular Dr. in Bozeman who checked the halo, readjusted it, and the pressure sore healed. This is active case management which involves listening to client, making suggestions and acting on information. This should have not been in lieu of skilled bed, I agree. However, active intervention prevented laceration from becoming totally infected by nurse. Resulted in active intervention to get brace aligned correctly to prevent more problems with deepening pressure sore and by getting brace adjusted prevented compression on cord due to ineffectual fitting of brace. Family not aware of these issues. Also ICM got patient into local Dr. versus driving 150 miles one way in car too small for someone with halo that is improperly fitted and a 150 mile drive home. There is cost savings on bed. HH savings not documented since we have price list and know Deaconess home health is $93/visit and ICM got another company for $65.

Auditor's Comments to VRI's Rebuttal: VRI's rebuttal indicates there was savings negotiated on a hospital bed which patient used while at home. VRI notes they negotiated bed from $148 to $115. According to file notes, it appears that fee variation is the price offered from one equipment vendor compared to another vendor. This represents a $33 per month savings, but technically is from price shopping, not fee negotiation. In the notes, patient received bed on 10/13 and returned it on 11/21, approx. a 5 wk period of rental, equal to $165 savings. VRI suggests saved money by requesting a skilled nursing visit for patient at home, based on the conversation they had with mother who seemed concerned about patient's halo jacket. Notes indicate visit priced at $65. No notes to demonstrate the original price. VRI's rebuttal indicates original price was $93 but they failed to document this information. Given this, savings =$28. Note that a skilled nursing visit at $65 is comparable to the fee for a physician's office visit and, in this case, the nursing visit did not save a trip to Dr. as patient did require an office visit. Unfortunately no real savings resulted from authorizing this home nursing visit. Coordination of physician visit closer to patient's home and the supportive conversations with the family during the course of this case were nice but no real saving impact noted. *Of the originally quoted savings of $1,085, $28 + $165 or $193 can be verified by documentation in the ICM record.*

Case ID# 8	Age:13	Diagnosis: Osteomyelitis of leg with endocarditis
Factor(s) Prompting Case Selection: Notice from an unknown person to review for outpatient antibiotics		
Date Case Opened: 10/7/94	**Date Case Closed:** 11/16/94	**# of Months in ICM:** ~1¼
Auditor's Original Comments: No evidence case managed; just monitored (which happens) but savings cannot be justified from monitoring. **Savings Realistic?** No evidence home IV's were in lieu of hospitalization. No evidence VRI thought up home IV plans it appears to have been doctor's orders all along. **VRI's Rebuttal to Auditor's Original Findings:** No rebuttal comments provided from VRI. **Auditor's Comments to VRI's Rebuttal:** *No rebuttal comments provided from VRI.*		

Case ID# 9	Age: 43	Diagnosis: Multiple sclerosis
Factor(s) Prompting Case Selection: Unknown — notes from this case management period seem to stem from a prior period		
Date Case Opened: 9/26/94	**Date Case Closed:** 10/21/94	**# of Months in ICM:** ~ 1

Auditor's Original Comments: On 9/30/94 home health asked for two visits and VRI appears to have authorized 3, as needed.

Savings Realistic? No. Claim IV meds at home saved an inpatient stay but no evidence inpatient stay was appropriate.

VRI's Rebuttal to Auditor's Original Findings: This is an odd case. The referral came from a neighbor of the patient who reported the patient needed help with the cost of the drugs. The referral came directly to the nurse because she knew the nurse did case management. You will note call was to client, Barbara. When you are not working, any additional money you pay causes problems. In reviewing doc, client very ill. Drs are making home visits. [Paracentesis] done in the home. This is usually a hospital procedure. ICM worked closely with family to get services provided at home so hospitalization not necessary. I have marked notes to indicate this man's physical condition. He certainly would have met criteria for some hospital days. Because of rapport with ICM did keep him at home because knew could get help when needed.

Auditor's Comments to VRI's Rebuttal: *There is nothing in VRI's rebuttal to alter the auditor's original findings that the $6,155 in estimated savings cannot be justified from the record.*

Case ID# 10	Age: 50	Diagnosis: Metastatic breast cancer
Factor(s) Prompting Case Selection: Patient called regarding need for home meds		
Date Case Opened: 12/26/95	**Date Case Closed:** 6/18/96	**# of Months in ICM:** ~6

Auditor's Original Comments: Seemed to be one step behind some vendors. Unaware of admit 5/96 and that on 6/12 hospice started. Notes indicated hospice referral would have been appropriate at least a week before started.

Savings Realistic? No evidence VRI's involvement produced savings.

VRI's Rebuttal to Auditor's Original Findings: Client called because she had her friend giving her injections of Neupogen and wanted to know if insurance could pay her friend. Under home health benefit this was possible and the bills were sent through regular benefits. Contact was maintained with client to determine if other interventions would be needed. Her disease progressed rapidly. Was rehospitalized in May. ICM not aware she remained hospitalized so long because of [an] error. Name was spelled wrong so did not come over again from precert when CSR was done. Went to another ICM who became aware that client had case manager when review doc.

Auditor's Comments to VRI's Rebuttal: *No savings originally estimated by VRI and no documentation in the medical records supports any savings.*

Case ID# 11	Age: 25	Diagnosis: Pregnant with pyelonephritis
Factor(s) Prompting Case Selection: Hospital called regarding home care benefits		
Date Case Opened: 11/22/95	**Date Case Closed:** 12/95	**# of Months in ICM:** ~1

Auditor's Original Comments: On 11/95 offered to assist with home IV antibiotics fee. Negotiated home health visit charges.

Savings Realistic? No documentation to support notion that home IV was in lieu of hospital stay.

VRI's Rebuttal to Auditor's Original Findings: Documentation however did not give you the picture of how this case came about. Since this is an MS patient, the chances of her having more SoluMedrol for this condition is very high. With this intervention she will probably have them all at home unless there is other complications. Patient is one who thought being in hospital may have been cheaper but again that is not documented. Had patient wanted to go inpatient it would have been approved as treatment for exacerbation with IV SoluMedrol so that [is] why nurse took hospital days as averted.

Auditor's Comments to VRI's Rebuttal: *Auditor finds no information in the medical record or in the rebuttal comments from VRI to substantiate the $6,210 estimated savings.*

Case ID# 12	Age:NB	Diagnosis: Premature at 27 weeks
Factor(s) Prompting Case Selection: Hospital called on admit		
Date Case Opened: 7/10/95	Date Case Closed: 6/19/96	# of Months in ICM: ~11

Auditor's Original Comments: Monitored case and tried to coordinate transfer back to Montana with transport fees but parents refused. Case managed while still an inpatient. Negotiated some equipment discounts.

Savings Realistic? Find evidence of $44.34 savings from negotiating apnea monitor discount; however, ICM fees exceed savings.

VRI's Rebuttal to Auditor's Original Findings: No interventions were able to be done since mom uncomfortable with bringing baby back to Montana. Was hoped as baby progressed she would allow transport back. Even two days back early would have given cost savings. Only got savings on apnea monitor.

Auditor's Comments to VRI's Rebuttal: *VRI and auditor agree that only savings is from negotiating a discount on the apnea monitor ($44.34).*

Case ID# 13	Age: 42	Diagnosis: Cystic fibrosis
Factor(s) Prompting Case Selection: VRI sent to ICM during concurrent review when doctor wanted DME		
Date Case Opened: 10/6/94	**Date Case Closed:** 9/16/95	**# of Months in ICM:** ~11

Auditor's Original Comments: Negotiated some equipment fees. Arranged to have ICM pay patient's 25% coinsurance responsibility—no evidence of patient's financial hardship.

Savings Realistic? No, cannot substantiate that home care was in lieu of hospitalization.

VRI's Rebuttal to Auditor's Original Findings: ICM asked to look at getting negotiated costs on equipment to save both insurance co. money and client money. Initial cost was $4800, it was misprint in doc. Negotiated down to $3750. At that time, ICM also inquired about home IV antibiotics which were then approved by the Dr., so seed planted. IVs do meet criteria so two additional days would have been paid if client preferred to stay in especially in this small community. Why would a patient go home if deductible [met] and MML met knowing they would now pick up copay on home health and meds. We don't document this but it is the reality.

Auditor's Comments to VRI's Rebuttal: VRI indicates that the documentation in the medical record on 8/1/95 has an inaccuracy. They indicate that the negotiated price was not $1,400 up to $3,750, but was instead $4,800 down to $3,750. This represents a savings of $1,050 for negotiation of an equipment discount. VRI suggests that it is illogical to think that the patient would have gone home knowing that his deductible had already been met without ICM's efforts in picking up the patient's coinsurance. The notes do not substantiate this information. *The auditor can verify $1,050 of the originally stated $5,265 savings.*

Case ID# 14	Age: 48	Diagnosis: Brain tumor with brainstem bleed needing removal
Factor(s) Prompting Case Selection: Hospital admit		
Date Case Opened: 1/12/95	**Date Case Closed:** At least 9/95	**# of Months in ICM:** ~9

Auditor's Original Comments: Negotiated discount on some home care visits. Offered to extend outpatient physical therapy benefits if patient continues to meet inpatient criteria. ICM picked up patient's 25% coinsurance responsibility for home PT. Appears to have exceeded inpatient rehab benefits. Researched prices on DME.

Savings Realistic? No. Documentation unclear as to whether fee negotiation resulted in any savings.

VRI's Rebuttal to Auditor's Original Findings: When ICM became involved client was given a week to live. He rallied, thoughts were for perdiem of hospice, but with improvements, may not be hospice. Nurse visits were negotiated down to $70. Client received IV hydration Fri, Sat and Sun. He could have been in hospital but was not, so this was taken as cost savings. There is financial difficulties. Fund raising going on. Because of improvement went to rehab. Client discharged but needs outpatient therapy and benefit is only $2000. Medical reviewer indicated would meet inpatient rehab criteria for another 10-14 days but will go home if therapy provided. Rehab costs $1500/day that is a savings of at least $15,000 so outpatient being paid beyond $2000. Was rehospitalized in May. Tried to again go to rehab but lacks endurance for program. Did eventually get to rehab again will need outpatient when home. Goal is to stretch out lifetime max of rehab. Discharged home. Continued to progress. In Sept, noted walk around the block. Closed to ICM since medical stable and was maintenance. I don't have savings sheet but with original rehab savings of $15,000 to $20,000 there was a savings. Also did negotiate PT prices.

Auditor's Comments to VRI's Rebuttal: VRI's rebuttal indicates that they claim there was a savings. *Auditor is unable to find clear documentation to substantiate the $20,607 originally estimated savings.*

Case ID# 15	Age: 57	Diagnosis: Throat cancer
Factor(s) Prompting Case Selection: Family called regarding admit		
Date Case Opened: 6/1/95	**Date Case Closed:** 5/6/96	**# of Months in ICM:** ~13

Auditor's Original Comments: Notes monitor patient's illness.

Savings Realistic? No evidence of any savings.

VRI's Rebuttal to Auditor's Original Findings: This patient being treated aggressively for cancer. On TPN to keep nutritional status up. Went in for surgery on 10-3-95 for tumor removal. Patient ended up trached. Was able to go home. Needed to be suctioned. HH had to get equipment in home to prevent her from choking. Medical stability precarious. Did stay home even though had mucus plugs, sob, pathological fractures of ribs. On O_2 as of 1-15-96. She could have been in the hospital. Without the support of ICM, if she had to do it on her own, she would have been admitted more than 3 times. This is a cost savings. From mid-March to death was in some type of facility.

Auditor's Comments to VRI's Rebuttal: VRI's rebuttal indicates that they believe they saved through their support of this patient. *The ICM record does not clearly document the $2,374 of savings claimed.*

Case ID# 16	Age: 62	Diagnosis: Thalamic hemorrhage (stroke)
Factor(s) Prompting Case Selection: Hospital called		
Date Case Opened: 5/4/95	Date Case Closed: 10/20/95	# of Months in ICM: ~5½

Auditor's Original Comments: Patient was approved for rehab however lacked cognitive skills to thoroughly benefit from such services.

Savings Realistic? No, notes suggest that use of extended care is an extracontractual benefit but plan document lists 70 days of SNF coverage and that transport fees were in lieu of hospital stay.

VRI's Rebuttal to Auditor's Original Findings: Did pay for ambulance because moved from skilled to less skilled facility and not a covered benefit. She remained in extended care bed until it was thought she would benefit from rehab. She however developed [aspiration] pneumonia and had to be rehospitalized. When recovered was again put in swing bed which did go through regular benefits. In Sept reviewed for rehab stay. Was decided she could benefit from a trial of rehab. Made some gains and was discharged. As you note in your doc. goal was to get independent enough for husband to care for her. Some of these goals were met.

Auditor's Comments to VRI's Rebuttal: VRI suggests they were instrumental in saving Montana on this particular case. *Auditor finds no clear evidence to verify the $1,440 of estimated savings.*

Case ID# 17	Age: 43	Diagnosis: Preterm labor with twins
Factor(s) Prompting Case Selection: Internal VRI referral		
Date Case Opened: 6/1/95	**Date Case Closed:** 1/19/96	**# of Months in ICM:** < 1 mo.

Auditor's Original Comments: Monitored course of illness. No evidence that VRI's involvement changed treatment plan that doctor and home health had planned.

Savings Realistic? No, no evidence of fee discount or alternate plan of care from what doctor was going to do.

VRI's Rebuttal to Auditor's Original Findings: ICM involved to pay for Terbutaline pump and monitor since this is not paid under benefits. I called customer service and spoke to Robin. If patient goes to Dr. office for Terbutaline, pays 75% of allowable. Not an option in this case, on bedrest. If given at home will pay for med but not pump and will not pay uterine monitoring, so ICM opens all of these cases in lieu of hospitalization. There is cost savings in using Terbutaline pump and uterine monitoring over inpatient stay. Got this client from 25 wks to 34 wks with twins. Twins born on 9-6-95 and discharged 9-8-95. Costs averted are for premies who could have been hospitalized if had been born at 25 weeks.

Auditor's Comments to VRI's Rebuttal: VRI's rebuttal suggests that the patient's home uterine monitoring and Terbutaline medication is not a payable benefit. Page 4 of the plan document under Home Health indicates that home health services are available to include nursing and medical supplies and drugs. Additionally, page 50 under Durable Medical Equipment does not indicate that home uterine monitoring is an exclusion nor does the auditor find an exclusion in the plan document on pages 60 through 62.

If however the home uterine and Terbutaline is NOT a covered benefit then the savings in this case is not from the authorization of these services minus the potential hospital stay of twins, but rather the expense of a hospital stay by the pregnant mother to control preterm labor versus the same care under home health services. *Without clarity on the benefit coverage issues, the auditor is unable to substantiate the $33,000 savings that VRI originally claimed.*

Case ID# 18	Age:NB	Diagnosis: Newborn twin with respiratory problem
Factor(s) Prompting Case Selection: Anonymous call to alert VRI of baby's transport to Level 2 nursery.		
Date Case Opened: 5/18/95	**Date Case Closed:** 5/31/95	**# of Months in ICM:** ~1

Auditor's Original Comments: Monitored case. No evidence VRI's involvement altered course of case.

Savings Realistic? No evidence VRI caused transports to a less expensive hospital.

VRI's Rebuttal to Auditor's Original Findings: Due to ICM intervention, baby was transported from more acute hospital to less acute. ICM paid ambulance since policy will not pay for ambulance from more skilled to less skilled even though cost effective. There was a cost savings with the transfer. See underlined doc.

Auditor's Comments to VRI's Rebuttal: VRI's records suggests that there was a cost savings that they are responsible for in having the baby leave one hospital and go to a lower care hospital. It is documented that the daily rate of the first hospital was $905 per day and the daily rate of the second hospital was $587 per day. However, the notes do not demonstrate that it was VRI's suggestion to make this transfer. Rather the notes on 5/8/95 indicate that VRI received a phone call from someone named S.Haney notifying them of plans to transport the patient to the second hospital. It's nice for Montana that there was a savings of $318 per day but this auditor cannot find that the savings is due to any intervention by VRI. *The originally estimated savings of $2,127 cannot be verified.*

Case ID# 19	Age: 61	Diagnosis: Lung cancer
Factor(s) Prompting Case Selection: Internal VRI referral		
Date Case Opened: 7/19/95	**Date Case Closed:** 10/19/95	**# of Months in ICM:** ~3

Auditor's Original Comments: Monitored case. Tried to negotiate swing bed rates but no evidence of success.

Savings Realistic? No evidence home IV's were in lieu of hospital stay.

VRI's Rebuttal to Auditor's Original Findings: Note in ICM doc of 8-23-95 condition of client. Pain out of control, suggested ICM could do IV meds. Suggestion taken and IV meds started on 8-30. Could have been in hospital for this but due to early ICM contact, home was place of choice. Hospital days averted. Swing bed negotiated at $100 so we know this was a savings since she could have stayed in acute in this condition. Working close with HH and family was able to get discharged home. Very ill from disease. On MS continuously. Died 8 days after home. If no ICM would have just, I believe, stayed in.

Auditor's Comments to VRI's Rebuttal: VRI's rebuttal indicates that the swing bed was negotiated at $100, however, the original fee is not documented nor the number of days applicable to the swing bed rate; consequently, savings cannot be calculated. VRI suggests that had they not been involved the patient would have remained as an inpatient. There does not appear to be documentation in the medical record to substantiate this claim. *Auditor remains unable to verify the originally stated $2,228 savings.*

Case ID# 20	Age: 62	Diagnosis: Multiple sclerosis
Factor(s) Prompting Case Selection: Internal VRI referral		
Date Case Opened: 3/1/95	Date Case Closed: 8/31/95	# of Months in ICM: ~5

Auditor's Original Comments: Monitored case. No evidence VRI's involvement altered course of case.

Savings Realistic? No evidence home IV meds were in lieu of hospital stay.

VRI's Rebuttal to Auditor's Original Findings: You indicated that no evidence IV meds in lieu of hospital stay. You will note that on 2-7-96 patient was admitted to facility for IV treatment. ICM discussed at that time that it would be more cost effective to do at home and would look at this in the future. Next note, client calling to see if could have treatment at home for IV. This was paid extracontractually and hospitalization was averted. Criteria would have been met if she would have wanted to go inpatient.

Auditor's Comments to VRI's Rebuttal: The notes do indicate that on 4/30 VRI received a telephone call from "Beverly" stating that she is calling about a SoluMedrol infusion that VRI had suggested could be done at home. There is, however, no documentation as to the average room and board rate in an inpatient setting minus the negotiated cost of home-based SoluMedrol infusions for a certain number of days. *Consequently, the originally stated savings of $1,231 cannot be verified.*

Case ID# 21	Age: 32	Diagnosis: Pregnancy with neonatal spine complications
Factor(s) Prompting Case Selection: Patient called regarding her pregnancy with complications		
Date Case Opened: 10/31/95	**Date Case Closed:** 11/17/95	**# of Months in ICM:** < 1 mo.

Auditor's Original Comments: Monitored case through delivery Once home, arranged to reimburse patient for breast pump. No evidence of financial hardship.

Savings Realistic? No evidence VRI's involvement produced measurable savings.

VRI's Rebuttal to Auditor's Original Findings: Breast feeding is documented in the literature to be superior since breast milk contains many antibodies that protect the newborn. In this case the baby had many medical problems and the OB case manager supported the mother's decision. Since mastitis is a complication of not emptying the breast adequately and mom was spending much time at the hospital with the babe[y], this appeared to be a way to assure mom would continue pumping her breasts since it is quicker than manually expressing the milk. It is not documented there is financial hardship, however this is not a normal babe[y] and since ICU is place babe[y] is in, parents will have medical bills just because of hospitalization. This babe[y] did not survive.

Auditor's Comments to VRI's Rebuttal: *VRI and auditor agree that there is no evidence of financial hardship. No savings was estimated nor can be supported by documentation in the records.*

Case ID# 22	Age: 37	Diagnosis: Colon cancer
Factor(s) Prompting Case Selection: Hospital called		
Date Case Opened: 12/2/94	Date Case Closed: 12/29/94	# of Months in ICM: ~ 1

Auditor's Original Comments: Coordinated custodial care for patient (nurses aid). Monitored illness. Did suggest hospice but it was not in lieu of anything. Negotiated $5.00/visit difference in home visits.

Savings Realistic? Unclear as to why VRI calls home care and ambulance as extra contractual as these are benefits listed in plan document.

VRI's Rebuttal to Auditor's Original Findings: ICM arranged for nurses aide since that is what was needed most of the time instead of the RN. State of Montana Customer Service Rep. Laura verified aides are not a covered benefit. RN and LPN would be covered but not aide so that is why done through ICM. Also ambulance not covered because it is going from skilled to less skilled area. Since this woman was dying from her cancer and was on TPN and Morphine PCA pump, she is not custodial. She had skilled needs. She however wanted to die at home and since home is cheaper than RN or LPN it was cost effective to provide level of caregiver that was needed. When negotiated perdiem for hospice this is more cost-effective because what policy pays for is fee for service and perdiem includes equipment, nursing care, etc. Since this client had many needs, more cost-effective to approve perdiem than fee for service at this point. Client died 12/27.

Auditor's Comments to VRI's Rebuttal: VRI's rebuttal indicates that they negotiated a perdiem for hospice as opposed to the fee-for-service price. A perdiem charge of $100 per day is in the notes; however, the original fee-for-service rate is not, therefore, *savings is unable to be verified.*

Note: Montana's plan document is confusing in that home health aides ARE a covered benefit on page 54 under L-28 Home Health Services yet Customer Services told VRI they were not covered. Also, the kinds of services an aide is allowed to perform (comfort, hygiene, convenience) are excluded on page 62 under M-32.

Case ID# 23	Age: 56	Diagnosis: Leukemia and liver failure
Factor(s) Prompting Case Selection: Wife called for home health		
Date Case Opened: 10/17/94	**Date Case Closed:** 11/11/94	**# of Months in ICM:** ~1

Auditor's Original Comments: Monitored care and gave support to wife. No evidence VRI's involvement altered course of case.

Savings Realistic? No evidence equipment rental was in lieu of hospital stay.

VRI's Rebuttal to Auditor's Original Findings: ICM involved with this client earlier than Sept 94 which is beginning of audit. Family was trying to find treatment options. This client was in the middle of a Master's research project on chronic lymphocytic leukemia so was looking at options. Was referred to customer service to see what insurance would pay for since some of options were experimental. Then in Oct wife called back and case reopened which is the doc you have. Note that ICM asked if home health more appropriate for treatment on this patient on 11-21-95. Dr. approached by discharge planner on home health and IVs. Dr. discharged on HH with IVs as requested. This was ICMs idea not Dr. Also this client lives in Broadus. There is not HH service there and certainly no IV service. Client left hospital and had to stay in Mile City to receive therapy. Client could have easily stayed in hospital due to environmental problems of services not being available yet arrangements were made because ICM would pay providers at 100% and client not responsible for copay and deductible so this was motivating factor. Days were averted as a result of ICM planting the seeds.

Auditor's Comments to VRI's Rebuttal: VRI's rebuttal indicates they asked if home health would be more appropriate for this patient on 11/21/95. The record indicates that the patient expired on 11/11/94. No notes in the ICM record on 11/21/94 or 10/21/94. *Auditor cannot find additional information which substantiates savings on this case.*

Case ID# 24	Age: 13	Diagnosis: Major depression with personality disorder
Factor(s) Prompting Case Selection: Appears to be an internal VRI referral		
Date Case Opened: 12/22/94	Date Case Closed: 1/9/95	# of Months in ICM: < 1 mo.

Auditor's Original Comments: Negotiating reduced room rate.

Savings Realistic? Perhaps, but notes do not substantiate pre and post fee negotiations thus savings cannot be calculated.

VRI's Rebuttal to Auditor's Original Findings: Enclosed is documentation showing 8 subacute days were approved in lieu of 4 acute inpatient days at half price which was $450/day. See doc. I am not sure why this wasn't printed for you with other doc. This then didn't save money overall yet allowed for longer treatment period. Client has not been readmitted so I believe you can say plan was successful.

Auditor's Comments to VRI's Rebuttal: VRI's rebuttal provided a new page of notes demonstrating that they negotiated a price of $450/day for subacute care compared to full inpatient rates. VRI's rebuttal indicates full price is approximately $900 a day. This would represent a $450/day savings; however, the original savings estimate stated the price of an acute hospital day as $1,376/day. The notes indicate that 8 subacute days were authorized. With varying prices for the original hospital day, the actual savings is either $926/day or $450/day over the original room rate. *Without clarification as to the original fee for the room rate, savings cannot be clearly verified.*

Case ID# 25	Age: 43	Diagnosis: Premature labor
Factor(s) Prompting Case Selection: Hospital called		
Date Case Opened: 2/23/95	**Date Case Closed:** 9/29/95	**# of Months in ICM:** ~7

Auditor's Original Comments: Monitored case. Note a discussion with patient about extracontractual benefits available but no further notes as to whether such benefits were approved and why.

Savings Realistic? No evidence VRI caused hospital transfer to University of Utah.

VRI's Rebuttal to Auditor's Original Findings: ICM didn't cause transfer to U of U however in early notes, ICM tried to intervene by paying for housekeeper to keep this lady on bedrest trying to prevent premature birth. Lady went on to deliver early; however, in a number of cases we have prolonged pregnancy by providing housekeeping, daycare, etc. to keep mom on bedrest. It didn't work in this [case] however, it has helped out in other cases.

Auditor's Comments to VRI's Rebuttal: VRI concurs that there is no evidence that their intervention caused a hospital transfer as was suggested by their original savings estimate. VRI does indicate that they offered housekeeper services. Housekeepers, like home health aides, deliver services which probably fall under Exclusion M-32 on services for convenience which are not primarily medical in nature. The auditor understands that the use of a housekeeper on a patient who is to be at bedrest is helpful. The auditor cannot find that the use of a housekeeper, a non-covered benefit, saved Montana and rather should be an added expense. *The originally claimed $16,782 savings cannot be substantiated by documentation in the ICM records.*

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SECTION XII - CASE MANAGEMENT RECOMMENDATIONS

The following will outline The Segal Company's recommendations to enhance the operations and effectiveness of case management services for the State of Montana. Our suggestions are in no particular order of importance or urgency and are divided into two sections: those which address our findings relative to VRI's performance and those directed to the State of Montana Employee Benefits Plan.

VRI Recommendations

1. Shift the emphasis of case management efforts from negotiating discounts on individual cases to redirection of patients toward providers where a previously negotiated discount arrangement is in place.

   With the clout of your review organization or that of Blue Cross and Blue Shield of Montana, consider developing a comprehensive network of ancillary providers (*e.g.* home health, home infusion therapy, hospice, skilled nursing facilities, physical therapy, etc.) for the patients of the State of Montana and for your own use in case management.

2. Consider shifting the emphasis of case management efforts to determining whether the physician or vendor is proposing the **most cost-effective/medically necessary** treatment plan and intervene to change a proposed plan to a more creative design and fiscally sound plan, where appropriate. Measure the difference between the plan the health team originally proposed and the new creative one VRI developed.

   For example:

   > Doctor orders home health 5 times/week for dressing changes and it is noted that the dressing changes could be done in the doctor's office daily at little or no cost. VRI's impact would be the difference between the cost for the home health visit and the fee for the office visit. There may even be no office visit fee as post-surgical physician visits are typically included in the global fee for the procedure itself.
   >
   > Or: Physician orders home health for wound care with no specific guidelines and it is noted that home health vendor plans to send out RNs for each visit. An alternative may be proposed which would utilize LVNs at a lesser per-visit cost with a stipulation that the home health vendor teach the patient/family how to change dressings. Savings would be the difference between the cost of RN visits and LVN visits times the number of total visits used.

3. Develop formal and comprehensive written screening guidelines specific to the kinds of situations confronting case management services (these criteria will be a little different than precert criteria for hospital admissions). Case management criteria should indicate when the

review staff can unilaterally approve the use of certain types of durable medical equipment, home health, infusion therapy, home uterine monitoring, skilled services, inpatient rehabilitation, etc. Such criteria should be reviewed by the State to assure that they are in agreement as to why certain services will be authorized, as they are the payor.

4. Consider **daily** case management team meetings with UM nursing staff and appropriate physician advisors to brainstorm ideas for complex patient case situations. Step back from long or tough cases and look retrospectively at them. Where were missed opportunities, what can be done now, what are the trends (*e.g.* repeat admissions for diabetes suggests increased individual patient education on diet and glucose monitoring, or notes seem to suggest that the family is learning a patient's care so that fewer home health visits should now be considered).

5. Develop a formal internal quality assurance program which monitors nurses application of criteria and operational protocol **and** analyzes VRI physician advisor's review decisions for creativity, accuracy and trends.

6. Refine reports to clearly demonstrate UM effectiveness. Assure that savings are valid, realistic, and are able to be verified/audited. Fee negotiation should demonstrate what the cost would have been at a pre-discount (*e.g.* fee-for-service) level minus the discount arrangement. Demonstrate savings from altering the treatment plan to clearly reflect the plan the health team would have implemented had VRI not been involved versus the plan VRI designed that the health team would not have considered.

7. Research the State's benefit limitations and relay these to the patient/health team before offering extracontractual benefit options. Help the team strategize how a plan of care can be developed that works within the benefit design, not outside. Given limitations, vendors can be creative and innovative when required. Where benefit limits are too restrictive for even the cleverest of care plans, discuss with the State how the plan document can be amended so that benefits are consistently applied across the State's plan population, not extracontractually for only certain individuals.

8. Take an assertive role in quickly suggesting, researching and implementing financial options for those unfortunate individuals who will have long term health care needs (*e.g.* quads, cancer, etc.). This may include Social Security, Medicaid and Medicare benefits as well as coordination of benefits with other insurance carriers. Consider not leaving this vital task to the discharge planner at a facility as they have little incentive to move quickly to secure long term financial alternatives before existing benefits run out.

9. When the clinical situation is appropriate, hold firm to your recommendations of non-certification for continued stay or admission. Do not allow providers to "blackmail" VRI into authorizing more inpatient days than the patient needs or demanding that if more home health care is not approved they'll be forced to readmit the patient. If the patient does not meet the medical criteria for an admission or continued stay, those services should not be authorized.

10. Consider tighter screening criteria for inpatient rehab use (*e.g.* Milliman and Robertson's criteria) so that patients with cognitive deficits (confused, inability or difficulty to learn or remember) do not use expensive inpatient rehab resources without maximum benefit and are instead managed on an outpatient and more cost effective.

11. Work with Blue Cross and Blue Shield to obtain a monthly "high/large claims report". The one obtained from Blue Cross for this audit listed all patients who had paid charges in excess of $100,000. If case management screening is working properly, UM should be finding every case that eventually becomes expensive. Checking monthly is a good way to assure that you have not overlooked a patient who should be case managed. Perhaps even lower the limit to all patients with paid claims over $50,000, to control the case early, not when the patient has reached $100,000.

12. On a few of the 25 cases audited, a physician advisor or the Medical Director was utilized. The notes do not document, however, that these physicians pursued investigation of alternative options before reaching a decision to extend confinement or approve the original request. All requests for review were determined in favor of the patient or requesting physician without further suggestions or innovative problem-solving to assist the staff nurses or conversation with the attending physician as to an alternative and perhaps more cost-effective route.

13. Consider reworking the bill matching/research function of case managers. The matching of a vendor's billed charges with the actual VRI authorized services could be handled by the claims department as with any other type of bill. The case managers are too expensive and valuable to use their time performing non-medically related services. When VRI authorizes a service through the case management process, a complete description of the information (*e.g.* vendor name, frequency of visit, cost for visit duration of visits, etc.) should be written allowing copies of the crucial information to be forwarded to the vendor/provider/facility, the patient, the claims department and one for the case manager's file.

14. Consider the recommendations for improvement in contract compliance as outlined in the Contracted Case Management Services section of this audit report.

State of Montana Recommendations

1. Consider eliminating the requirement for a contract/agreement between the patient/family and VRI prior to initiation of case management services. This may require a plan amendment to L-37 on Managed Care Services and to the VRI contract with the State to indicate that case management is not an option for plan participants but an integral part of the State's benefit plan design.

2. Designate a date by which VRI must submit, for your approval/modification, written screening criteria for use in managing your cases.

3. Develop or lease a comprehensive discount network for ancillary health care vendors. Consider discussing with VRI and Blue Cross whether they will develop this network for you (and their other clients) or whether the State should consider performing, or subcontracting for, direct contract development. You may want to require that any ancillary provider contract contain language that holds the provider accountable for complying with your UR/QA program administrator. Fee negotiation on an individual basis costs both time and dollars in search of the "best" prices. Negotiation is particularly difficult at the time the service is needed, as vendors know they have the "upper hand".

   This may involve some of the following steps:

   - With VRI's assistance, make a list of the type of ancillary health care providers most frequently needed during case management, such as home health, home infusion services, durable medical equipment, non-durable medical supplies, hospice, skilled nursing facilities, outpatient rehabilitation providers such as physical therapy, occupational therapy and speech therapy, as well as inpatient rehabilitation facilities. Then note the locations within Montana where the majority of cases are managed. Also note the locations outside the State of Montana where patients must go for services not able to be provided by Montana hospitals, such as Seattle, Portland, Salt Lake City and Denver for transplants, burns care, neurosurgical services and inpatient rehabilitation.

   - If Blue Cross or VRI is unable or unwilling to negotiate for discounts, consider direct negotiations on behalf of your own plan population as the largest employer in the State. You may even consider creating a purchasing coalition with other large employers in the State such as the power company, etc. to create an undeniably important and impressive volume of health care purchasers with whom most health care vendors would **vie** to be the designated PPO vendor.

   - Consider a plan design modification with differing financial emphasis such that in-network (contracted provider) benefits are paid at a higher coinsurance than out of network providers. This steerage should provide an incentive for participants to use your network providers, will protect the patient from balance billing and those associated out of pocket costs, and save the State's claim costs. A 20% coinsurance differential between in-network and out-of network should dramatically shift utilization toward the more cost-effective discount arrangements (*e.g.* 80% in-network and 60% out of network).

   - Should the State develop a comprehensive ancillary network of provider discounts then VRI can simply direct or redirect the patient and health care team toward the designated contracted vendors to take advantage of the preset discounts. This eliminates significant case management hourly billing and correspondence. Also VRI can then notify the State where there may be "holes" in the network or instances where they have found that deeper discounts may be available than those which have been negotiated. Reserve fee negotiation for only those cases where there is no

contracted provider (*e.g.* inadequate geographic coverage, patient or physician refusal to use contracted provider, etc.)

4. Once an ancillary network is in place, amend the VRI contract to require that they attempt to redirect plan participants toward contracted providers at every opportunity.

5. Assure clarity in the purpose of case management for your plan population. Is it to be a vehicle to extend benefits and does your plan have the financial stability to proceed with this philosophy or is case management a tool to save costs? Section L-37 of the State of Montana plan document has language which could be considered ambiguous, suggesting cost-savings is a goal yet offering options "not normally available under the health plan."

6. Reconsider the use of extracontractual benefit allowances, both in terms of picking up the patient's coinsurance differential and extending benefit limitations. Extracontractual benefits are not typically viewed as savings to a plan, rather extra expense. Modify the existing plan design limitations via plan amendments to allow uniform access by all plan participants if the State determines that certain limits are too confining for a majority of participants and this is in the best interest of your program's financial picture.

7. Consider implementing meetings (at least quarterly) between the operations staff of VRI, representatives from the claims administrator and the State benefit department. The purpose of the meetings would be to track and trend health care use, problem-solve and review long term and expensive case managed individuals.

8. Consider discussing with Blue Cross their ability to match authorized case management services with the vendor's bills as a claims function, not a case manager's job, so as not to compromise the medical expertise of the case manager and the associated time-charges with clerical duties.

9. Consider monitoring large claim reports from Blue Cross and Blue Shield with a list of cases VRI has under their case management program to assure that VRI is managing all your potentially expensive individuals. You may even want to consider a computer link to VRI with the terminal located within your benefit department (with proper password protection) so that the benefit manager can access the VRI case management screens to monitor progress. Typically no data entry or manipulation is possible under this type of arrangement but "watching" allows the benefit manager to keep abreast of progress and problems as they happen, not at the end of the month or quarter.

10. Once new procedures and expectations are confirmed, consider a re-audit of VRI in 9 to 12 months to determine the level of improvement and validation of realistic savings.

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SECTION XIII - VRI RESPONSE

October 3, 1996

To: Ms. Nancy Hakes
FROM: Carlotta Hecker

RE: Response to audit

Dear Ms. Hakes,

I will address each case and fax with this note issues I need you to relook at that does give supporting documentation for cost savings.

Case # 7–Cervical fracture after fall. You indicate that Dr.s orders and family requests were followed and fees may have been negotiated but were not documented.

Response. When ICM met with the client and family they initially requested a hospital bed. You will note in documentation that the nurse suggested they try their bed at since its not usual for a hospital bed to be needed for this condition. Notes do indicate the client tried his water bed and a day bed, both of which were not tolerable. A rate was then negotiated on the bed from $148 to 115. I have underlined this. All so in the nurses judgment a skilled nurse visit was set up to check on this patient do to complaints if blurred vision , laceration on eye brow and unstable due to halo brace.

When the nurse went out she called ICM with, pussy laceration, which she cleaned, suture removal at no extra cost, identified sore under sheepskin of halo brace support. Early identification of the sore resulted in the ICM nurse contacting the treating Dr. in Billings to see if a local Dr. could evaluate the fit of the halo, address the pressure sore, and check the pin sites. This was done and approval given. ICM contacted the mother of the client to set up an appointment with regular Dr. in Bozeman who checked halo, readjusted it, and the pressure sore then healed. This is active case management which involves listening to client, making suggestions, and acting on information.

This should have not been in lieu of skilled bed, I agree. However, active intervention prevented laceration from becoming totally infected by nurse visit. Resulted in active intervention to get brace aligned correctly to prevent more problems with deepening pressure sore and by getting brace adjusted prevented compression on cord due to ineffectual fitting of brace. Family not aware of these issues. Also ICM got patient into local Dr. versus driving 150 miles one way in car to small for someone with halo that is improperly fitted and a 150 mile drive home. There is cost savings on bed, HH savings not documented since we have price list and know Deaconess home health is $93 per visit and ICM got another company for $65.

I have enclosed parts of documentation to address this with this note.

CASE # 9 Multiple sclerosis

This is an odd case. The referral came from a neighbor of the patient who reported the patient needed help with the cost of the drugs. The referral came directly to the nurse because she knew the nurse did case management. You will note call was to client, Barbara. When you are not working any additional money you pay causes problems.

In reviewing doc. client is very ill. Dr.s are making home visits. Parenthesis done in the home. This is usually a hospital procedure. ICM worked closely with family to get services provided at home so hospitalization not necessary. I have marked notes to indicated this mans physical condition. He certainly would have met criteria for some hospital days. Because of repore with ICM did keep him at home because knew could get help when needed.

Case # 22 Colon cancer

ICM arranged for nurses aide since that is what was needed most of the time instead of the RN. State of Montana Customer Service Rep. Laura verified aides are not a covered benefit. RN and LPN would be covered but not Aide so that is why done through ICM. Also ambulance not covered because it is going from skilled to less skilled area. Since this women was dying from her cancer and was on TPN and Morphine pca pump she is not custodial. She had skilled needs. She however, wanted to die at home and since home is cheaper then acute care it was cost effective to pay for the ambulance. Since aide is cheaper then RN or LPN it was cost effective to provide level of care giver that was needed.

When negotiated per diem for hospice this is more cost effective because what policy pays for is fee for service and perdiem includes equipment, nursing care ect. Since this client had many needs more cost effective to approve perdiem then fee for service at this point. Client died 12/27.

Case #21 Pregnancy with neonatal complications

Breast feeding is documented in the literature to be superior since breast milk contains many antibodies that protect the new born. In this case this baby had many medical problems and the OB case manager supported the mothers decision. Since mastitis is a complication of not emptying the breast adequately and mom was spending much time at the hospital with the babe, this appeared to be a way to assure mom would continue pumping her breasts since it is quicker them manually expressing the milk. It is not documented there is financial hardship, however, this was not a normal babe and since ICU is place babe is in, parents will have medical bills just because of hospitalization. This babe did not survive.

Case # 20 Multiple sclerosis

You indicated no evidence IV meds in lieu of hospital stay.---You will note that on 2-7-96 patient was admitted to facility for IV treatment. ICM discussed at that time that it would be more cost effective to do at home and would look at this in the future.

Next note, client calling to see if could have treatment at home for IV. This was paid extracontractually and hospitalization was averted. Criteria would have been met if she would have wanted to go inpatient.

Case #11 pregnancy

Documentation however didn't give you the picture of how this case came about. Since this is an MS patient the chances of her having more solumederol for this condition is very high. With this intervention she will probably have them all at home unless there is other complications. Patient is one who thought being in hospital may have been cheaper but again that is not documented. Had patient wanted to go in patient it would have been approved as treatment for exacerbation with IV solumederal so that I why nurse took hospital days as averted.

Case # 12 Prematurity

No interventions were able to be done since mom uncomfortable with bringing baby back to Montana. Was hoped as baby progressed she would allow a transport back. Even two days back early would have given cost savings. Only got savings on Apnea monitor.

Case #13 Cystic Fibrosis

ICM asked to look at getting negotiated costs on equipment to save both insurance co. money and client money. Initial cost was $4800, it was misprint in doc. Negotiated down to 3750. At that time ICM also inquired about home IV antibiotics which were then approved by the Dr. so seed was planted. Ivs do meet criteria so two additional days would have been paid if client preferred to stay in especially in this small community. Why would a patient go home if deductible meet and MML met knowing they would now pick up copay on home health and meds. We don't document this but it is the reality.

Case 25

ICM didn't cause transfer to U of U however in early notes ICM tried to intervene by paying for housekeeper to keep this lady on bedrest trying to prevent premature birth. Lady went on to deliver early however, in a number of cases we have prolonged pregnancy by providing housekeeping, daycare ect. to keep mom on bedrest. It didn't work in this however, it has helped out in other cases.

Case # 24 Major depression

Enclosed is documentation showing 8 subacute days were approved in lieu of 4 acute impatient days at half price which was $450.00 per day. See doc.. I am not sure why this wasn't printed for you with other doc. This then didn't save money overall yet allowed for longer treatment period. Client has not been readmitted so I believe you can say plan was successful.

Case # 23 Leukemia

ICM involved with this client earlier then Sept. 94 which is beginning of audit. Family was trying to find treatment options. This client is a was in the middle of a masters research project on chronic lymphocytic leukemia so was looking at options. Was referred to customer service to see what insurance would pay for since some of options were experimental. Then in October wife called back and case reopened which is the doc., you have.

Note that ICM asked if home health more appropriate for treatment on this patient on 11-21-95. Dr. approached by discharge planner on home health and Ivs. Dr. discharged one on HH with Ivs. as requested. This was ICMs idea not Dr. Also this client lives in Broadus. There is not HH service there and certainly no IV service. Client left hospital and had to stay in Mile City to receive therapy. Client could have easily stayed in hospital due to environmental problems of services not being available yet arrangements were made because ICM would pay providers at 100% and client not responsible for copay and deductible so this was motivating factor. Days were averted as a result of ICM planting the seeds.

Case #10 Breast Cancer

Client called because she had her friend giving her injections of neupogen and wanted to know if insurance could pay her friend. Under home health benefit this was possible and the bills were sent through regular benefits. Contact was maintained with client to determine if other interventions would be needed. Her disease progressed rapidly. Was rehospitalized in May. ICM not aware she remained hospitalized so long because of a error. Name was speiled wrong so did not come over again from precert when csr was done. Went to another ICM who became aware that client had case manager when review doc.

Home health working with client and regular benefits applied. Reason hospice called was they were looking at per diem and this has to be extra contractual if done. Benefit pays fee for service. Per diem not negotiated. Client died very quickly. Client was on intrathecal methotrexate . She had already used 51 of 70 visits by May 29th. When all used was more cost effective to keep at home since with methotrexate could have been in hospital but with hospice involvement did not exceed 70 visits since rest was sent through hospice benefit.

Case # 19 Lung cancer

Note in ICM doc. of 8-23-95 condition of client.Pain out of control, suggested ICM could do IV meds. Suggestion taken an IV meds started on 8-30. Could have been in hospital for this but due to early ICM contact home was place of choice. Hospital days averted. Swing bed negotiated at 100.00 so we know this was a savings since she could have stayed in acute in this condition. Working close with HH and family was able to get discharged home. Very ill from disease. On MS continuously. Died 8 days after home. If no ICM would have just I believe stayed in.

Case #18 Newborn

Due to ICM intervention baby was transported from more acute hospital to less acute. ICM paid ambulance since policy will not pay for ambulance from more skilled to less skilled even though cost effective. There was a cost savings with the transfer.. See underlined doc.

Case #16 CVA

Did pay for ambulance because moved from skilled to less skilled facility and not a covered benefit. She remained in extended care bed until it was thought she would

benefit from rehab. She however developed aspirate pneumonia and had to be rehospitalized. When recovered was again put in swing bed which did go through regular benefits. In sept. reveiwed for Rehab. stay. Was decided she could benefit from a trial of rehab. Made some gains and was discharged. As you note in your doc. goal was to get independent enough for husband to care for her. Some of these goals were met.

Case #17 preterm labor

ICM involved to pay for tributalene pump and monitor since this is not paid under benefits. I called customer service and spoke to Robin. If patient goes to Dr. office for Tribut. pays 75% of allowable. Not an option in this case , on bedrest. If given at home will pay for med but not pump and will not pay uterine monitoring so ICM opens all of these cases in lieu of hospitalization .. There is cost savings in using Tribut.. pump and uterine monitoring over inpatient stay. Got this client from 25 weeks to 34 weeks with twins. Twins born on 9-6-95 and discharged 9-8-95. Costs averted are for premies who could have been hospitalized if had been born at 25 weeks.

Case # 14 Brain tumor

When ICM became involved client was given a week to live. He rallied, thoughts were for perdiem of hospice, but with improvement, may not be hospice. Nurse visits were negotiated down to 70.00 Client received IV hydration Friday , Saturday, and Sunday. He could have been in hospital but was not so this was taken as cost savings.There is financial difficulties. fund raising going on. Because of improvement went to Rehab. Client discharged but needs outpatient therapy and benefit is only 2000.00

Medical reviewer indicated would meet inpatient rehab criteria for another 10-14 days but will go home if therapy provided. Rehab costs 1500 per day that is a savings of at least 15,000. so out patient being paid beyond 2000.00. Was rehospitalized in May. Tried to again go to rehab. but lacks endurance for program. Did eventually get to rehab. again will need outpatient when home.

Goal is to stretch out lifetime max of rehab benefit. Discharged home . continued to progress. In sept. noted walk around the block. Closed to ICM since medical stable and was maintenance. I don't have savings sheet but with original rehab. savings of 15,000 to 22,000 there was a savings. Also did negotiate PT prices.

Case # 15 Throat cancer

This patient being treated aggressively for ca. On TPN to keep nutritional status up.Went in for surgery on 10-03 -95 f r tumor removal. Patient ended up trached. Was able to go home . Needed to be suctioned. HH had to get equip. in home to prevent her from choking. Medical stability precarious. Did stay at home even though had mucus plugs, sob, pathological fractures of ribs. On 02 as of 1-15-96. She could have been in the hospital Without the support of ICM, if she had to do it on her own, she would have been admitted more then 3 times. This is a cost savings. From Mid march to death was in some type of facility.

Case #1 In complete quad.

There is a 60 day rehabl. benefit. He chose to go home early and with outpatient therapy it was possible.Admitted 4-1- 1994. Discharged home around may 21. Used only 33 days. By my review of notes he would have met criteria for Rehab for the entire 60 days. ICM took the 27 days as savings to pay for the out patient services since policy only covers 2000.00 ICM claimed 40,000 dollars which figures out to $1481 which is the cost of a day on the unit. You could ask any physiatrist and I believe as long as the patient makes gains they stay on the unit. Considering how young he is he would have stayed 60 days so I believe this was the savings they worked off of for
paying outpatient. Care plan was for 4 months so could have closed in Oct. of 94.

Case #2 Leukemia

ICM did request home Ivs if possible. Dr. took suggestion and client discharged on home Ivs. Also discounted price from $425 to 324 per day for 5 days. see notes.. also negotiated neupogen from 300/day to 200/day.

Case #3 paraplegic

Patient had 60 day benefit. Did use 51 days on first admit. was discharged because could not do more rehab. while in body jacket. Plan was to discharge until jacket removed and readmit to complete rehab. Medical director at that time Dr. Maher tried to get patient back to Montana but mother would not agree. Cost savings realized on wheelchair.Original price $3402. Negotiated to 2,675. Home health was deducted from regular benefit. Medicaid eventually approved and part of second admit covered by Medicaid. Later admit was following mva. HH ordered but went through regular benefits.

Case #4 Leukemia

Did get cost negotiated on TPN. Because of ICM mixedTPN was used while inpatient instead of wasted. goal in this case was to extend transplant benefits by getting best prices for supplies and try to provide as many services on outpatient basis as possible. Benefit was eventually used up and child went on Medicaid.

Case #6 osteo and diabetes.

ICM introduced idea of home Ivs. A perdiem for antibiotics was arranged at $152/day. In the end client wouldn't sign extracontractual agreement and all services went through regular benefits. Cost savings occurred when bills were submitted for the per diem of antibiotics which was less then the insurance company would have paid if negotiations had not occurred. Aide was going to be paid through ICM as not a covered benefit yet cheaper then RN.

Case #5 severe diabetes

This is a very long involved case as you noted. This individual was very ill during the entire case. In reviewing the do. it is apparent to me that without the relationship she

developed with case management she would have been hospitalized many more times then she was and would have met criteria. Due to length of case notes I will not resubmit just ask that you review closely for criteria and I know you will find that she could have been in several more times but outpatient services were offered to her which she took.

SECTION XIV - STATE ADMINISTRATION RESPONSE

DEPARTMENT OF ADMINISTRATION
STATE PERSONNEL DIVISION

MARC RACICOT, GOVERNOR

MITCHELL BUILDING, ROOM 130
PO BOX 200127

STATE OF MONTANA

(406) 444-3871
FAX: (406) 444-0544

HELENA, MONTANA 59620-0127

October 25, 1996

Ms. Mary Anne L. Watson
The Segal Co.
5080 N 40th Street, Suite 400
Phoenix, AZ 85018

Dear Ms. Watson:

I have received your audit report on administration of the State Employee Benefit Plan and provide the following response to your recommendations.

1. Review of Service Team Efficiency

RECOMMENDATION:

BCBS'S Internal Audit Department is in the process of preparing for their initial audit following establishment of Service Teams. We encourage BCBS to share their findings with the State.

RESPONSE:

We concur with this recommendation.

2. Subrogation/Third Party Liability

RECOMMENDATION:

The State and BCBS should revisit their October 12, 1995 discussion to ensure that all subrogation claims activity is tracked and reported on a regular basis. The purpose of these reports is two-fold: 1) to provide accurate record of monies recovered on behalf of the State, and 2) to advise the State

of possible cases that may warrant pursuit of recovery. We recommend the State implement the 6-month trial basis proposed in their response to our prior report.

RESPONSE:

We concur with this recommendation. A report will be generated for BCBS indicating the monies recovered on behalf of the state.

3. Reports

RECOMMENDATION:

It is unclear whether the concern over claims data reports was resolved since our last audit report. It is critical that the format meets the State's requirements as the State relies on such data for program evaluation. BCBS should contact the State to discuss and identify any additional State requirements that have been provided in the standardized format.

RESPONSE:

We concur with this recommendation. BCBS has provided more detailed and reliable reports at our request, and have agreed to modifications.

4. State Review of Eligibility Discrepancies

RECOMMENDATION:

Delays in the State's review of eligibility discrepancies can result in payment of participant claims past the termination date of coverage. The State should review their current procedures to assure eligibility edits identified by BCBS are researched and returned to BCBS within 5 work days.

RESPONSE:

Under the current eligibility tracking system it is not possible for BCBS to pay claims on a member past their termination date, providing BCBS is loading the State tape accurately. Since September 1994, all terminations are processed by BCBS directly from the eligibility tape. Because of the new process, the "discrepancies" BCBS identifies are not usually related to coverage; they are most likely birth date or sex inconsistencies or missing primary care physician codes, none of which would result in claims payment past the termination date.

5. Retroactive Eligibility Status Changes

RECOMMENDATION:

BCBS should review their procedures for the identification of retroactive changes in eligibility status. These procedures should require prompt notification to the appropriate service team so that claims can be adjusted when necessary.

RESPONSE:

Although retroactive changes do not occur very often, they need to be processed as consist and promptly after they are identified so claims adjustments can be made if necessary. We are unaware of problems associated with retroactive claims adjustments.

6. Emergency Room Expenses

RECOMMENDATION:

System edits for covered emergency room charges, based solely on the hospital's primary diagnosis, should provide consideration for the type of treatment rendered (i.e. revenue codes for extensive laboratory and surgical expenses). Current edits resulted in the denial of a sampled claim we

feel may have met BCBS's written definition of medical emergency had the claim been submitted to medical review.

RESPONSE:

We concur with this recommendation and look forward to BCBS's recommendation. Currently, when emergency room claims are denied, because of the way in which it was submitted, (i.e. without a sudden and serious diagnosis code) corrections are only made for members who appeal the denial (assuming it meets the sudden and serious criteria).

7. Hospital Ancillary Expenses

RECOMMENDATION:

Prior to September 1, 1996, inpatient durable medical equipment expenses were paid at a reduced benefit level without further review of appropriate revenue classification. Eligible ancillary charges for two claims identified in our review were reimbursed at the lower level. The State and BCBS should discuss whether these claims will adjust based on current processing guidelines.

RESPONSE:

Prior to September 1, 1996, this only occurred with subscribers on the HMO plan. The current processing guidelines will treat all inpatient DME expenses the same regardless of what medical plan the member has chosen. A meeting will be scheduled with BCBS to discuss disposition of the two claims identified.

8. Hospital Primary Diagnosis Edits

RECOMMENDATION:

Eligible equipment and services are determined by LRSP system edits based on primary diagnosis codes submitted by the

hospital. BCBS should establish a threshold (i.e. $250) whereby claims can be suspended for review of additional reported diagnosis that may substantiate medical necessity.

RESPONSE:

In light of BCBS's response we will determine the factors considered and review the need for other criteria.

9. Unbundling and Upcoding Edits

RECOMMENDATION:

Unbundling and upcoding has been identified as a provider practice to maximize benefit reimbursements. Similar to BCBS procedures for identification of unbundled surgical procedures, we feel additional system edits could be developed to identify certain services that should be subject to review prior to payment. For instance, all new patient codes and individual tests that should be classified as multi-channel laboratory services can be flagged by CPT code.

Standard insurance industry guidelines require automated or manual detection of unbundled and upcoded services. We have found that most major insurance carriers and their party administrators utilize purchased or company developed software for this purpose as a routine administrative service.

RESPONSE:

We concur with this recommendation.

10. Workers' Compensation

RECOMMENDATION:

Our prior report recommended that the State provide BCBS with reports of all work injuries. BCBS could then place

appropriate notations in their claims system for identification of potential work related claims that require additional investigation and/or denial under the State's medical plan. We received no indication that this recommendation was implemented or discussed with BCBS.

RESPONSE:

This recommendation was implemented effective September 1, 1996. A monthly report is generated and sent to BCBS for identification of possible duplicate claims payments.

We would also like to revisit previous audit recommendations #2 and #4 and further clarify what we are currently doing.

2. Reimbursement Allowances

RECOMMENDATION:

The impact of reimbursement guidelines relative to nonparticipating providers both in-state and out-of-state should be periodically reviewed to determine the financial impact on employees for utilization of these providers.

RESOLUTION:

In addition to participating in BCBS's nation wide ITS processing system the State has implemented the following procedure:

For all in-state and out-of-state emergency and accident claims (Class Codes 7 and 27, by nonparticipating providers), if the difference between charge and allowance is less than $100, charges are allowed. If the difference is $100 or more, pricing is set at the 90th percentile MDR of ZIP code in which services were provided. This is coded for walk-in clinics, critical care physicians, emergency medical physicians, emergency room multiple doctors billed by hospital, rural health clinics, and medical assistance facilities. All other

related services on the same day are paid the same way. The goal of this policy is to limit out-of-pocket costs where there is no choice of the professional provider.

4. Eligibility Discrepancies

RECOMMENDATION:

BCBS should suspend claims processing on all participants who appear on their monthly discrepancy list until such time as the State reconciles the report or determines appropriate coverage. It is imperative that the State review monthly discrepancy lists without delay.

A complete data coverage reconciliation should be conducted at the time the State's new benefits computer system goes into effect with special emphasis on self-pays; verification should be continued on a quarterly basis.

RESPONSE:

The BCBS "discrepancy list" processing has changed considerably since the State changed to a new computer system on September 1, 1994. BCBS is notified of all current coverage via the State's eligibility tape. Since BCBS no longer receives and independently enters coverage data, coverage discrepancies no longer exist between State coverage information and BCBS coverage information. All information on coverage and premium collected is reconciled internally within the State Insurance System before being transmitted to BCBS. Most of the questions presented by BCBS are to clarify their edit reports, to be able to accurately enter manual changes into their system, so coverage reflects that on the State's tape. Other questions involve birth dates that do not match those received from a provider on a claim, or missing primary care physician codes. Many of these questions come from BCBS per phone, and are answered at that time. If information is needed from a member, the State forwards it to BCBS as soon as the member responds.

The State is scheduling a meeting with BCBS to discuss the State tape processing and edits, so both parties are clear as to their roles and responsibilities.

We appreciate the thoroughness of your audit report, and the opportunity to respond.

Sincerely,

Joyce Brown
Chief, Employee Benefits